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Citing relevant studies and providing statistical data in 29 figures and 28 tables in the text and 15 appended tables, the report describes the characteristics of Texas' three major ethnic groups, Anglos, Latin Americans, and Negroes; discusses mental retardation in relation to socio-cultural factors, deprivation, health factors, education and illiteracy, and migrancy; and considers the characteristics of residential school enrollment. One bibliography cites 70 items; a second annotates 52 items on Latin American migrant labor. Guide questions for Negro and Latin American group meetings and excerpts from the Texas migrant health project are included. (JD)

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The Doubly Disadvantaged

A STUDY OF SOCIO-CULTURAL DETERMINANTS IN MENTAL RETARDATION

Charles Meisgeier

THE UNIVERSITY OF TEXAS
1966

EC 003 042

THE
DOUBLY DISADVANTAGED

**A Study of
Socio-cultural Determinants
in
Mental Retardation**

**by
CHARLES MEISGEIER**

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This study was undertaken for:

THE TEXAS MENTAL RETARDATION PLANNING STUDY
Stuart C. Fisher, M. P. H., Planning Director

THE GOVERNOR'S INTERAGENCY COMMITTEE ON MENTAL RETARDATION PLANNING
Bill Cobb, Chairman

THE GOVERNOR'S ADVISORY COMMITTEE ON MENTAL RETARDATION PLANNING
The Honorable Herman Jones, Chairman

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Foreword

Much suffering and needless waste of human potential are hidden in the tables and figures of this manuscript. Poor prenatal care, negligible care during childbirth, poor nutrition, and environmental impoverishment of every kind go on reaping their grim toll year after year. The simple safeguards and experiences that most Americans take for granted are almost unheard-of among certain large segments of the Negro and Latin-American communities of Texas.

Because of the interrelatedness of deprivation and mental retardation, the institution of health, educational, employment, and welfare programs necessary to combat mental retardation would also go a long way toward alleviating the crushing misery of poverty and vice versa. Texas has both the resources and the knowledge to abolish the conditions which are the breeding grounds of certain kinds of mental retardation and other crushing afflictions. It is hoped that the facts contained in this report will reveal more fully than before how much needs to be done to combat and ameliorate mental retardation among the Negroes and Latin Americans of Texas.

Acknowledgments

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CHAPTER I

INTRODUCTION

Of the 50 states of this nation, 28 have a total population smaller than that of Texas' ethnic minority groups, the Negroes and the Latin Americans. The smaller of the two, the Negro population of Texas, exceeds the population of 15 states and the District of Columbia and is concentrated in an area larger than that of several states.

These two groups are of significant size. They share the human needs of all men, and they have special needs because they have special problems. They are concentrated in areas tending toward little industrial and economic development; this means frequent unemployment, underemployment, low wages, and the resultant bitterness of widespread poverty. Closely related are factors of poor education and illiteracy. The mean school grade completed by Texas Negroes is 8. 4; for Latin Americans, only 5. 8. The proportion of illiteracy in the Negro and Latin-American population is almost four times that of the Anglo group. Completing this miserable picture are health records indicating that Negroes and Latin Americans suffer significantly poorer health and all its consequences than do Anglos.

The assault on the complex problems of mental retardation can no longer be considered apart from society's other needs. The mentally retarded person is affected by activities of the state and nation in all areas of endeavor. If we think of the Negro and Latin-American population of Texas as states within a state--and this is not too fanciful since they are groups of significant size, concentrated in certain sections and separated by barriers--we have a picture of a significant segment of our national territory and population characterized by gross deprivation and disadvantage in every area--physical, medical, economic, educational, social, and political.

It is obvious that all of this must have some effect on the problem of mental retardation. But what is the nature of the effect, and how extensive is it? Recent studies have pointed out that there is a higher prevalence of mental retardation among disadvantaged persons. The disadvantages of the Negro and Latin-American groups of Texas have been described and will be detailed in subsequent chapters, but how do these factors influence the problem of mental retardation? Actually, very little is known about the degree, frequency, and treatment of mental retardation in these groups. Standard measures of probability indicate that there are approximately 100, 000 persons in the Negro and Latin-American population of Texas who are mentally retarded, but details relative to their perceptions, attitudes, interpretations, and reactions to the problem of retardation have never been adequately studied.

One fact is known; Negroes and Latin Americans do not use community services for assistance with this problem in the same way as Anglos do, and not to an extent proportionate to their presence in the population. Community services are generally developed and operated by Anglos who may be ignorant of the cultural heritage and attitudes of Latin Americans and Negroes and, therefore, ill-prepared to help them. On top of that, Latin Americans, the larger group, have language difficulties when discussing their problems with Anglo community service workers. Hopefully, this study will help to penetrate some of the darkness surrounding the problem of mental retardation in the minority ethnic groups of Texas. Certainly much more research and study must be concentrated on this problem if Texas is to combat mental retardation among the Negroes and the Latin Americans.

CHAPTER II

CHARACTERISTICS OF TEXAS' THREE MAJOR ETHNIC GROUPS

Procedures and Definitions

The Latin-American and Negro groups of Texas are significant in size; their combined population is larger than the total population of 28 states. It is necessary to look at some of the characteristics of these groups in detail to understand their perceptions of mental retardation and how they might be affected by, and react to, such problems.

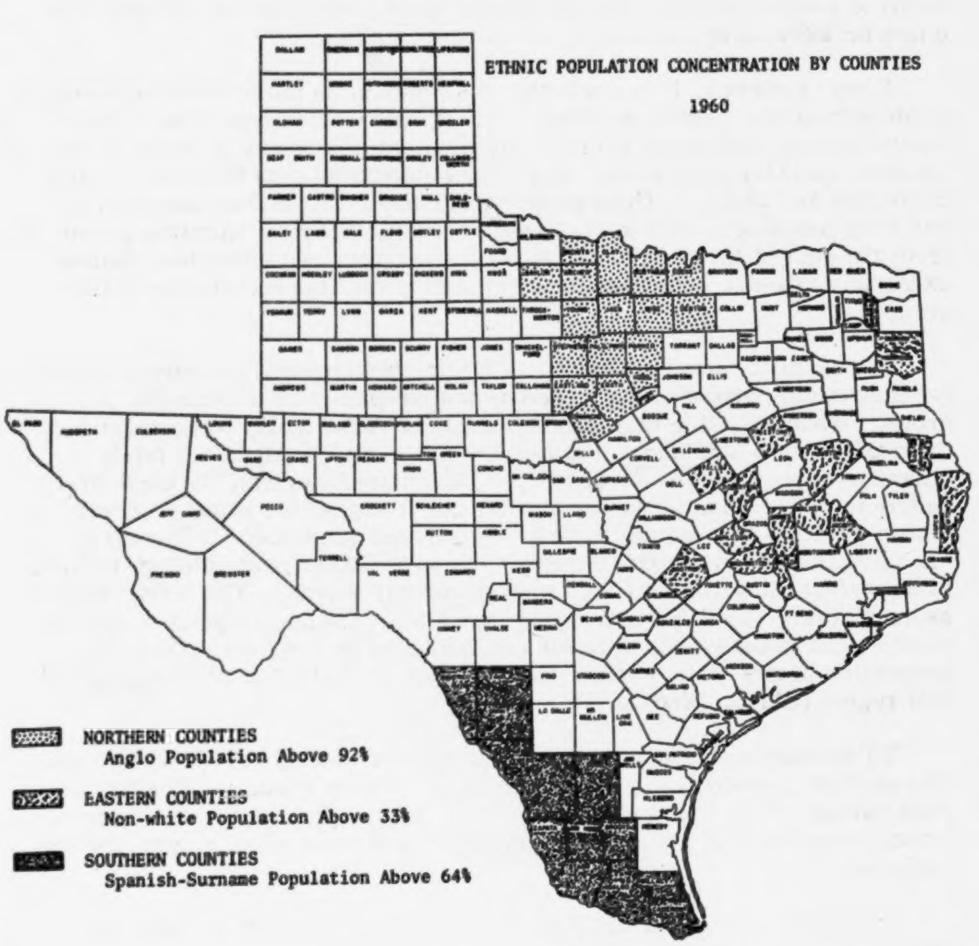
First, however, it is important to comment on the terminology used to identify ethnic groups in Texas. All studies of this type done in the Southwest are confronted with the problems of what name to apply to the Spanish-speaking population. For group statistical data they are usually classified as "white." Through extraordinary effort and cooperation it has been possible in this study to delineate this Spanish-surname group from the rest of the population, making the tables and other information extremely unusual and valuable in evaluating the characteristics of this group.

The term "Spanish surname" is fairly objective and somewhat useful for statistical purposes, but it seems inappropriate as a name for this group. When speaking in Spanish, members of the group often refer to themselves as a Mexicano, but the English word "Mexican" is fairly universally regarded as derogatory. "Mexican-American" is used fairly widely in some parts of the Southwest, but it engenders some disregard among persons not wanting to be a "hyphenated American." The term "Latin American" is most frequently heard in Texas; and although it, too, is imperfect, it will be utilized throughout this report. The term "Anglo" as used refers to all English-speaking whites. Clapp has pointed out that most statisticians equate data for non-whites with Negroes, since the proportion of non-whites other than Negroes is negligible in this geographical region (Clapp, 1966, p. 2).

To substantiate data describing the three ethnic groups it was decided that another technique should also be used. Three clusters of counties, each having a very high proportion of one of the ethnic groups in its population, were chosen; and different types of data from these counties were analyzed.

Seventeen contiguous counties in the northern part of the state were chosen to represent the Anglo population; these counties have a total population of 376,730, of which only 1.9% is Spanish surname and only 2.5% is Negro. Likewise, 12 counties in the extreme southwest portion of the state were chosen to represent the Latin-American population; the mean Spanish-surname population of these counties was 73.8%. Sixteen counties in the eastern part of the state, with a mean Negro population of 42%, were chosen to represent that group (see Figure 1). Data from these cluster of counties will be referred to throughout this study.

FIGURE 1



ETHNIC POPULATION CONCENTRATION BY COUNTIES

1960

▨ NORTHERN COUNTIES
Anglo Population Above 92%
▨ EASTERN COUNTIES
Non-white Population Above 33%
■ SOUTHERN COUNTIES
Spanish-Surname Population Above 64%

TABLE 1

TEXAS POPULATION CHANGES BY ETHNIC GROUPS 1950, 1960, 1965

	POPULATION				PERCENT OF POPULATION			
	1950[1]	1960[1]	Percent Gain 1950-1960	1965[2]	1950	1960	1965	Change in Percent of Population 1960-1965
Anglo	5,699,079	6,957,021	22.2	7,570,000	73.9%	72.6%	72.2%	-.4
Spanish Surname	1,027,455	1,417,810	37.1	1,610,000	13.3%	14.8%	15.3%	+.5
Negro	984,660	1,204,846	22.4	1,310,000	12.8%	12.6%	12.5%	-.1
TOTAL	7,711,194	9,579,667	24.2	10,490,000	100.0%	100.0%	100.0%	

[1] A Statistical Profile of the Spanish-Surname Population of Texas
Bureau of Business Research, The University of Texas

[2] Projection, Texas State Department of Health

Population, Employment, and Income Characteristics

Population Characteristics

Figures in Table 1 indicate that the Negro and Spanish-surname groups comprise a large segment of Texas' population and are a significant population group in the United States. In 1965 it was estimated that the Anglo population of Texas comprised 72.2% of the total state population; 15.3% was Spanish surname, and 12.5% Negro. The Spanish-surname proportion of Texas' population has been steadily increasing--from 13.3% in 1950 to 14.8% in 1960 to an estimated 15.3% in 1965. These figures indicate a 37.1% population gain during the decade 1950 to 1960. The percent of population gain for Anglos and Negroes was almost equal during the same period, with 22.2% gain for the Anglo population and 22.4% for Negroes. The Negro proportion of population remained relatively steady, showing very little change over the 15 year period, ranging from 12.8% in 1950 to 12.5% in 1965. The Spanish-surname population of Texas is expected to continue to grow at a faster rate than the other Texas ethnic groups.

> One comment should be made concerning differential growth of the three ethnic groups of Texas. Although the Spanish-surname population currently is growing at a much faster rate than the rest of the population of the state, it would be unwarranted to conclude from this that, within a short time this group could "take over" as numerically dominant. If, for example, the 1950-1960 rates for all three groups were to remain unchanged for the period 1960-1980, the proportion of the total population represented by the Spanish-surname group would rise only to 17.9 percent; and, if the same rates were to be extended to the year 2000, the figure still would be not more than 21.6 percent. However, this should be considered only as an exercise in projection, for it is virtually certain that growth rates for all the ethnic groups will change within the next forty years. For example, it is quite probable that the high rate of natural increase of the Spanish-surname population will decline somewhat, while it is doubtful that immigration into this country from Mexico will rise appreciably above its present levels. (Browning and McLemore, 1964)

Figures 2 and 3 indicate the Texas counties with 25% and 50% or more Negro (non-white) and Latin-American (Spanish-surname) population.

Figure 4 indicates the percentage distribution of the Texas population by age, and strikingly points out the younger ages of the Negro and Latin-American population group. Table 2 indicates the median age for each of the ethnic groups in 1960.

TABLE 2
Median Age of Texas' Three Major Ethnic Groups, 1960

	Anglo	Latin American	Negro
Median Age	29.5	18.0	24.1

The proportion under 14 years of age for the three groups is of interest since percentages applied to determine prevalence of mental retardation are usually higher in younger age groups. The proportion of persons in the Texas population under age 14 by ethnic groups in 1960 is indicated in Table 3.

TABLE 3
Texas Population Under Age Fourteen Years By Ethnic Group

	Anglo	Latin American	Negro
Under Age 14	20.1%	44.5%	36.9%

Only 10.5% of the Negroes and 5.7% of the Latin Americans were above age 60; the Anglo percentage was 12.4%.

Unemployment

The Negro and Latin-American ethnic groups have a considerably higher rate of unemployment than does the Anglo. The unemployment rate for the Negro population is over twice that of the Anglos. Clapp reported that the 1960 ratio of unemployed Latin-American and Negro men to the total male civilian labor force was 8.0% and 9.7% respectively, as compared with 4.5% for the Anglos in a five-state area of the Southwest. (Clapp, 1966.)

Income

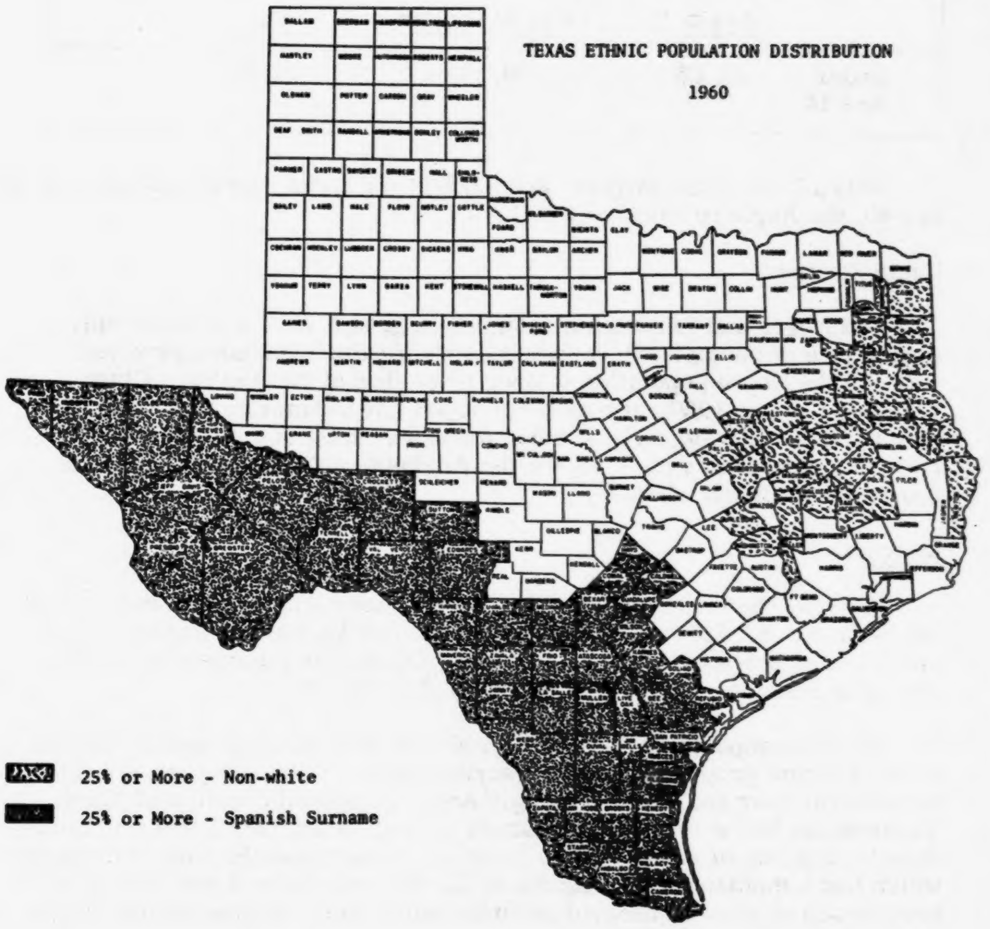
In 1959, the median earnings for all persons with income was $1,150 for Negroes, $1,536 for Latin Americans, and $2,700 for Anglos. For employed males age 14 and over, the Negro median income was $1,924, the Latin American, $2,029, and the Anglo, $4,137.

This discrepancy is correlated with the unequal geographical distribution of ethnic group population described above. Table 4 presents data for several poor but overwhelmingly Anglo-populated counties of North Texas which had a 1960 median family income of $4,028; Table 5 presents data for a group of southwestern counties, predominantly Latin-American, which had a median family income of $2,590; and Table 6 presents data for a group of eastern (Negro) counties which had a median family income of $2,663.

Prevalence of Mental Retardation

By using the generally accepted prevalence figure of 3% of the population as mentally retarded, it can be estimated that 314,700 individuals in the state of Texas are mentally retarded. A minimum of 48,300 Latin Americans, 39,300 Negroes, and 237,100 Anglos would fall into the category of the mentally retarded as represented in Table 7.

FIGURE 2

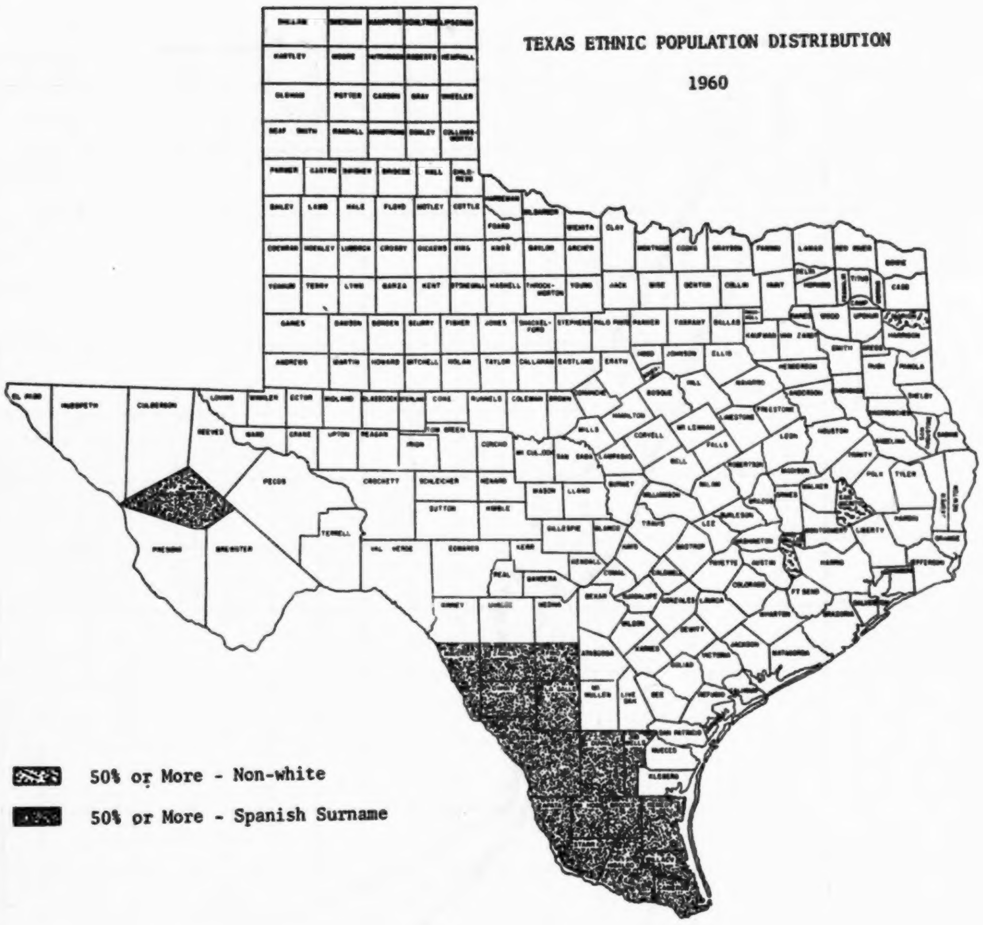


TEXAS ETHNIC POPULATION DISTRIBUTION

1960

Source:
U.S. Bureau of Census. U.S. Census of Population: 1960. General Population Characteristics, Texas. Persons of Spanish Surname. U.S. Government Printing Office, Washington, D. C.

FIGURE 3


TEXAS ETHNIC POPULATION DISTRIBUTION

1960

Source:
U.S. Bureau of Census. U.S. Census of Population: 1960. General Population Characteristics, Texas. Persons of Spanish Surname. U.S. Government Printing Office, Washington, D.C.

FIGURE 4

PERCENTAGE DISTRIBUTION OF TEXAS POPULATION
BY AGE

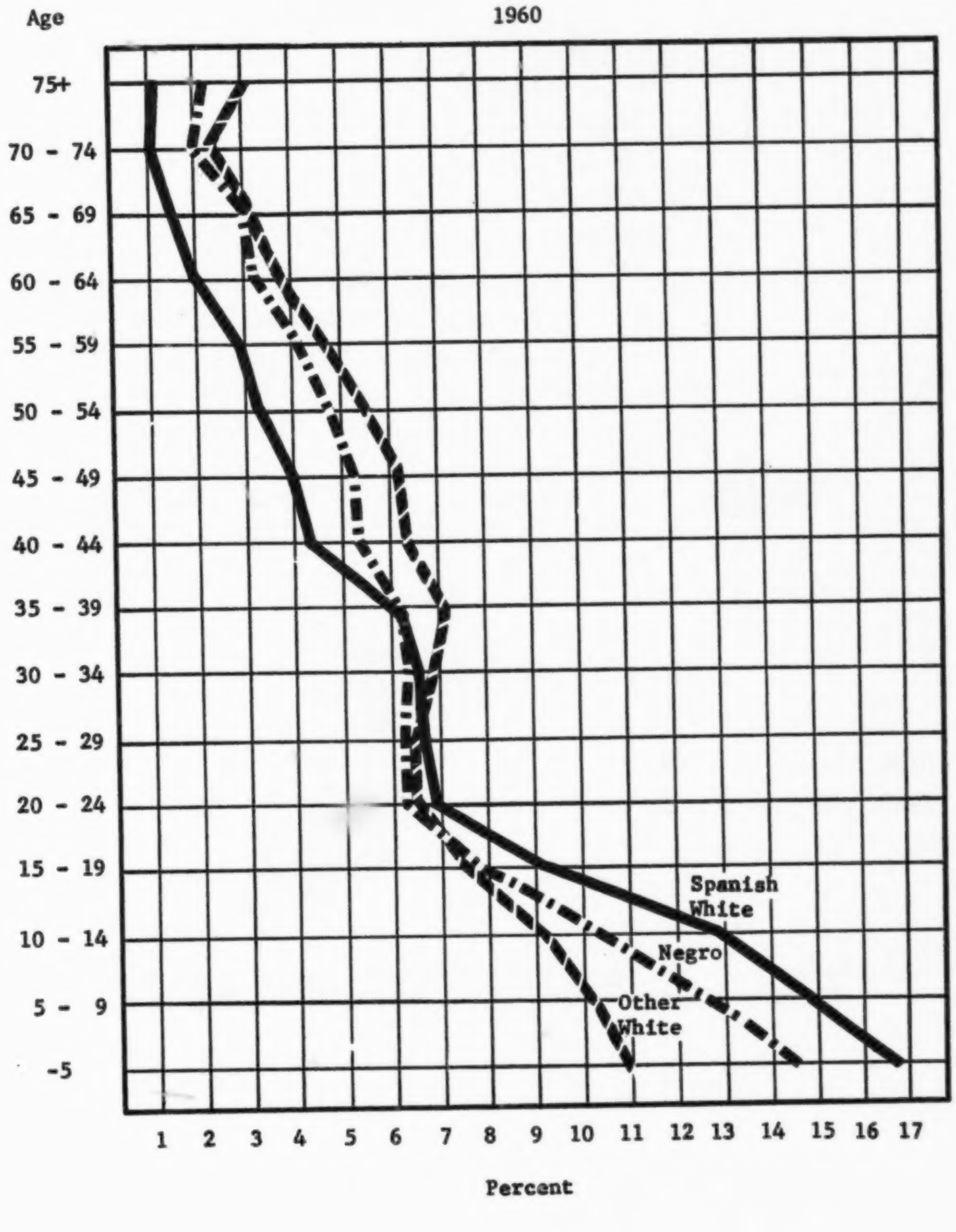


TABLE 4

POPULATION, INCOME, AND EDUCATIONAL CHARACTERISTICS OF COUNTIES WITH ANGLO POPULATION ABOVE 91.8% (1960)

County	Total Population[1]	Percent Non-white[2]	Percent Spanish Surname[1]	Median Family Income Total County Pop.[2]	Median School Years Completed Total County Pop.[2]
Archer	6,110	0.5	0.8	$4,590	10.3
Baylor	5,893	4.0	2.2	3,825	10.0
Clay	8,351	1.0	1.3	4,478	10.0
Comanche	11,865	0.1	2.0	2,747	9.4
Cooke	22,560	3.8	1.9	4,288	9.9
Denton	47,432	6.3	1.9	4,595	11.1
Eastland	19,526	1.8	4.2	3,324	9.7
Erath	16,236	0.9	0.9	3,111	10.4
Hood	5,443	1.0	1.8	3,282	9.6
Jack	7,418	1.2	0.8	4,375	9.9
Montague	14,893	.0	0.8	3,484	9.5
Palo Pinto	20,516	4.5	4.2	3,936	10.4
Parker	23,808	2.0	2.1	4,053	10.5
Stephens	8,885	4.5	2.2	4,443	10.7
Wichita	123,528	8.2	2.8	5,322	11.5
Wise	17,012	0.9	1.4	4,127	9.8
Young	17,254	1.6	1.2	4,588	10.1
17					
TOTAL	376,730				
MEAN		2.5	1.9	$4,028	10.2
TEXAS MEDIAN				$4,884	10.4

[1] A Statistical Profile of the Spanish-Surname Population of Texas, 1960, Bureau of Business Research, The University of Texas.

[2] U. S. Census of Population, 1960, Texas, General Social and Economic Characteristics, U. S. Department of Commerce, Bureau of the Census.

TABLE 5

POPULATION, INCOME, AND EDUCATIONAL CHARACTERISTICS OF COUNTIES WITH SPANISH-SURNAME POPULATION ABOVE 64%
(1960)

County	Total County Population[1]	Percent Spanish Surname[1]	Median Family Income[1] Span.-Surname Pop.	Median Family Income Total Co. Pop.[2]	Median School Years Completed[1] Span.-Surname Pop.	Median School Years Completed Total Co. Pop.[2]
Brooks	8,609	68.8%	$2,121	$3,222	4.8	7.1
Cameron	151,098	64.0%	2,206	3,216	3.9	7.9
Dimmit	10,095	67.0%	1,721	2,480	2.3	5.2
Duval	13,398	73.8%	2,152	2,878	5.1	6.9
Hidalgo	180,904	71.3%	2,027	2,780	3.3	6.3
Jim Hogg	5,022	76.8%	1,885	2,357	4.5	6.1
Maverick	14,508	77.5%	2,047	2,523	3.9	5.6
Starr	17,137	88.6%	1,568	1,700	4.3	4.9
Webb	64,791	79.9%	2,425	2,952	5.4	6.4
Willacy	20,084	68.3%	1,973	2,902	2.8	6.1
Zapata	4,393	74.7%	1,395	1,766	4.1	5.2
Zavala	12,696	74.3%	1,732	2,314	2.3	4.5
12						
TOTAL	502,735					
MEAN		73.8%	$1,938	$2,590	3.9	5.8
TEXAS MEDIAN					6.15	

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[1] A Statistical Profile of the Spanish-Surname Population of Texas, 1960, Bureau of Business Research, The University of Texas.

[2] U. S. Census of Population, 1960, Texas, General Social and Economic Characteristics, U. S. Department of Commerce, Bureau of the Census

TABLE 6

POPULATION, INCOME, AND EDUCATIONAL CHARACTERISTICS OF COUNTIES WITH NEGRO POPULATION OF 33% OR ABOVE
(1960)

County	Total Population[1]	Percent Non-white[1]	Median Family Income Total County Population	Median School Years Completed Total County Population
Bastrop	14,842	35%	$2,805	7.9
Burrelson	9,801	35%	2,451	7.8
Falls	18,623	37%	2,287	8.1
Freestone	12,387	40%	2,361	8.7
Grimes	11,805	41%	2,223	8.1
Harrison	44,966	44%	3,723	9.4
Houston	18,982	39%	1.901	8.6
Marion	7,971	53%	2,351	8.7
Morris	21,447	42%	4,912	9.8
Newton	10,271	33%	2,548	8.1
Robertson	14,808	44%	2,468	8.2
San Augustine	7,700	39%	2,233	8.1
San Jacinto	6,102	53%	1,737	7.4
Walker	20,850	34%	2,787	8.5
Waller	11,365	57%	3,219	9.3
Washington	15,915	38%	2,614	7.7
16				
TOTAL	247,835			
MEAN		42%	2,663	8.4

---

[1] U. S. Census of Population, 1960, Texas, General Social and Economic Characteristics, U. S. Department of Commerce, Bureau of the Census.

TABLE 7

ESTIMATED NUMBER OF MENTALLY RETARDED BY ETHNIC GROUP
1965

	Texas	Anglo	Negro	Latin American
Total	314,700	227,100	39,300	48,300

CHAPTER III

SOCIO-CULTURAL FACTORS AND MENTAL RETARDATION

In the previous chapter, several statistical differences among the three major ethnic groups of Texas were pointed out. It can be safely assumed that these differences have a bearing on the problem of mental retardation and the way in which this problem is perceived and handled by persons of the different ethnic groups.

It is possible, however, that an even greater influence on perceptions and attitudes about the problem of mental retardation is exerted by factors of culture and tradition which may vary from one ethnic group to the next. It would appear to be necessary to study the cultural beliefs and practices of the Negro and Latin-American groups in Texas in order to determine the nature and degree of any divergence of their beliefs and practices from those of the Anglo group. From such a study it might be possible to infer the effect which any existent cultural differences might have on the incidence, perception, and reaction to the problem of mental retardation.

It was felt that two approaches would be needed to accomplish such a study. First, a review of the literature on the subject of cultural practices would be helpful as a base from which appropriate inferences could be made. Second, it was felt that the experience and knowledge of welfare and service agency personnel who serve primarily Negro and Latin-American persons would be of value in testing those inferences made from the review of the literature. This chapter, then, is arranged in three sections: the first two summarize a review of the literature on the Latin-American and Negro cultures respectively; the last section summarizes the ideas of a three-group discussion of this subject.

Factors of Latin-American Culture Affecting Mental Retardation

Sources of Information

In attempting to study the affective relationship between the Latin-American culture of South Texas and the problem of mental retardation, one is immediately struck by the almost complete lack of information in the literature about this specific affective relationship. A report of the President's Panel on Mental Retardation, the Bibliography of World Literature on Mental Retardation, contains over 16,000 references, none of which pertains to this subject in the strictest sense, and only a handful of which were relevant in an even broader sense. Likewise, a bibliography of materials relating to the education of Spanish-speaking children compiled by Professor George I. Sanchez listed no appropriate references to this topic among its 882 annotated entries. A few sources do exist in the area of culturally oriented health practices, but several of these are repetitive and overlapping since they draw their material from the same source. The Hidalgo Project, an anthropological study of the health beliefs and practices of the Latin Americans of Hidalgo County, Texas, furnished the source for the reports of Albino Fantini (1962), William Madsen (1964), and Arthur Rubel (1966).

Exploration of the literature on such varied other subjects as medical care for, and education, cultural practices, cultural deprivation, and mental retardation of Latin Americans produced only a very few general references dealing with this subject area. The literature, then, is helpful in studying this subject only to the extent that it enables one to make inferences about this specific area from the general discussions of some of the above named topics. For example, there is a great deal of literature on the effects of cultural deprivation and the remediation of these effects by special education techniques; obviously, it can be inferred that much of this information about culturally deprived children in general will also hold true in the specific case of the Latin-American child of South Texas. One must, however, avoid the pitfall of overinference and concommitant overgeneralization about this unique cultural group.

Complicating the problem even more is the lack of homogeneity among the Latin Americans of South Texas, precluding any generalized statements about what "they" believe or practice. People of Latin-American descent obviously exist along the entire spectrum of education, socioeconomic status, and acculturation to the Anglo middle-class standard of values. Gonzales, Ratliff, and others have shown a rather high correlation between advanced education and middle and above socioeconomic status with Anglicization; conversely, low education and low socioeconomic status are generally associated with more traditional Mexican folk beliefs and practices (Gonzales, 1932; Ratliff, 1960). But these correlations are only generalized trends and should not be allowed to obscure the complexity of interrelationships which obviously must be determined for each and every individual who is affected to any extent by his antecedent culture. It should be kept in mind, then, that many of the cultural beliefs and practices which will be discussed below may be held by only some of the people of this culture and may be held by them with varying degrees of intensity and modification at different times in their lives.

Disease Theory and Health Practices

With these limitations, Fantini describes the disease theory and practice which is generally associated with the Latin-American culture of South Texas and which has many implications for the diagnosis, care, and treatment of mentally retarded persons. Oversimplifying, diseases are seen as of being of two general types: natural and unnatural (*mal puestos*). Among the former are those infirmities which can be judged to be natural occurrences and, therefore, amenable to the routine cures of home remedy or Anglo physician. The latter group, *mal puesto* , includes the unnatural diseases which result primarily from problems of social interaction. These are, for example, *mal de ojo*, which may be caused by a covetous glance from friend or foe; *susto* or *espanto*, which are the "fright" diseases; and there are many others. This latter group can sometimes fall into the category of "witchcraft" in that they can either be caused accidentally or be the evil design of some angry or jealous rival. These diseases are seen by the *Mexicanos* as being unique to their culture; since the Anglo physician does not have an understanding of these diseases, he is very rarely consulted for their remediation (Fantini, 1962).

It is possible that until recently mental retardation may not have existed as a specific medical entity in the traditional folk medicine of the *Mexicano* culture. Various conditions which could be technically diagnosed as mental retardation may be considered by the *Mexicano* to fall into several different groups of infirmities in his framework of disease theory. Thus retardation could be thought of as having variable etiology in folk culture, including being "natural" infirmities or disabilities, being the result of a divine punishment for some transgression, or being the end result of a curse or bewitchment made manifest in a *mal puesto*. Fantini noted that the *males puestos* most often were manifested "as a neural injury or psychic ill such as epilepsy, nervousness, paralysis, dementia, and feeble mindedness. Congenital deformities ... may also be attributed to witchcraft." He further noted that "Defects of many kinds and even mental retardation may often be regarded the same as any other innate physical characteristic. The mentally retarded child may be described as *flojo* (lazy) or *distraido* (inattentive, absent minded)." (Fantini, 1962)

Obviously, this variability of etiology has considerable implication for treatment. Rubel noted that the *Mexicano* looks upon disease and illness in pragmatic terms. That is, he does not consider himself to be ill unless he feels significant pain or discomfort. His goal then becomes the removal of this pain or discomfort, and whatever means serves to accomplish that end is viewed as efficacious medical treatment. The sufferer may explore many different resources for alleviation of his illness; and being treated by an Anglo physician and a *curandero*, or folk healer, simultaneously is not at all uncommon. It is also quite common for the *Mexicano* to experiment with all different kinds of patent medicines, herbs, teas, and other folk medicine preparations while simultaneously taking medicine recommend by a physician. This eclectic approach to medical treatment is mentioned by Madsen and Rubel as being one of the paramount characteristics of this cultural group (Madsen, 1964; Rubel, 1966).

Another major characteristic is the idea of the inevitability of disease. Again quoting from Fantini, "Fatalism pervades the life of the Latin-American population... in cases of illness where a cure seems hopeless, the problem may even be ignored by the Mexican." The implication for the mentally retarded child is obvious as he further states that "Seldom does one consider that the (mentally retarded child) might be helped. Seldom is therapy or rehabilitation considered. The afflicted must learn to fare as best he can with the endowments he possesses." Fatalism also has implications for the whole area of preventive medicine. In a culture which holds to the belief that disease is an inevitable part of a life which at best is often miserable, the whole concept of taking preventive action to forestall illness is largely absent. As stated above, medicine of all kinds, folk and technical, is relied upon only for the alleviation of existing pain or discomfort, and the possibility of preventing the illness in the first place is apparently not generally accepted in the *Mexicano* culture. (Fantini, 1962)

Thus it can be seen that the whole concept of disease theory which exists among the Latin Americans in South Texas has many negative implications for effective prevention and treatment of mental retardation. There are many other practices and aspects of this culture which impinge upon different areas of retardation, affecting its incidence and treatment.

Primary among these is the whole area of prenatal care and birth process. Since pregnancy is not regarded as a disease, the necessity for medical care is not recognized among most of the women of this culture. There are many folk beliefs concerning pregnancy, ranging from the rather bizarre belief that the moon consumes portions of the unborn fetus and causes deformities on birth (Fantini, 1962) to the idea that mothers should avoid eating certain foods during pregnancy for fear of creating a permanent digestive problem for their future child (Kelly, 1965). To protect her child the mother may wear a string around her waist, holding a piece of metal over her abdomen. The fact, then, that physical ailments and most forms of mental illness and abnormal behavior of any kind are attributed to supernatural causes that require special kinds of folk medicine has obvious important implications for the diagnosis and treatment of mental retardation.

The Role of the Midwife

The actual birth of the child is traditionally assisted by a midwife in the mother's home rather than in a hospital. There seem to be several reasons for this. One is that childbirth is considered a rather normal process; and many mothers, particularly those who have already had several children, simply appear not to see the need for any special provisions. Also, the atmosphere of the maternity ward of hospitals is so alien and different to many of these women that the fear of this strange world may outweight any fear of problems they may have during the birth process. There exist throughout the Latin-American community older women, parteras, who are widely known for their experience in midwifery. They usually charge very nominal fees and give much service additional to that which the mother could expect from an Anglo doctor and hospital, including staying with the mother for a week or two after the delivery of the child. This preference for delivery by midwife seems to be dying out, however, and more young Latin-American mothers are starting to go to the hospital to have their babies. The art of midwifery is apparently somewhat on the decline, since in one study of a small community there was much concern about the fact that all of the local parteras were above 50 years of age, and no young women were going into the "profession" (Saunders, 1954).

Figures in Chapter 5 dramatically show the decline in midwife and home deliveries for the Spanish-surname population for the years 1948-1965. In 1948 approximately 1/3 of all Spanish-surname births were midwife deliveries, whereas in 1965 this figure had dropped to about 1/10 of all births. There was a corresponding decline in home deliveries over the same time period from 61.7% to 11.2%.

Nutrition, Ethnicity, and Mental Retardation

Another whole area, influenced by culture and affecting mental retardation, is that of diet. The President's Panel on Mental Retardation has called attention to the relationship between poor maternal and infant nutrition and mental and physical disability and retardation. Blazek studied the food habits and living conditions of Latin-American families of different income levels. The diets were found to be extremely poor, even at the higher income levels; there was a significant absence at the low income levels of all vegetables, fruits, milk, and other protein and vitamin substances (Blazek, 1938). Although this detailed study of diet and nutrition is now somewhat out-of-date, there is more recent, albeit less thorough, data indicating that dietary deficiencies are still very common among the lowest socioeconomic group of the Latin-American population. One can infer the relationship between the diet of an expectant mother and the health of her baby; there is also the problem of inadequate diet for children after birth which would be related to certain types of mental retardation. Indeed, Pasamanick questioned all the studies comparing *Mexicano* and Anglo children because such factors as significantly poorer diet, lower birth weight, and inherently inferior socioeconomic status were uncontrolled variables in these studies which, in his opinion, undoubtedly worked against the Latin-American groups (Pasamanick, 1951).

Social View of Illness

A corollary area to medical beliefs and practices is the social context in which illness and treatment in the Latin-American culture takes place. Several authors (Clark, 1959; Fantini, 1962; Rubel, 1966; Spielberg, 1959) place great emphasis on the fact that all illness in the traditional *Mexicano* culture is a matter of social concern, especially to the immediate family of the ill person. For instance, when a child becomes ill, the first resource is the mother who has been trained from her own girlhood to provide simple home remedies and care to her family. If the child does not respond fairly soon to this home treatment, however, his illness becomes a matter for concern of the whole family. In particular, the older female members of the extended family, such as grandmothers, aunts, godmothers, etc., will all be brought in for consultation as to what should be done next in the treatment of the illness. In most families, the patriarchal system is still sufficiently present so that the father is most likely to have final say in the course of treatment. The important factor, however, is that the illness of one member of the family is seen as a problem for the entire family, and the family's resources may be mobilized to seek whatever treatment is decided as necessary, whether it be the services of a *yerbero* (herbalist), a *curandero*, or an Anglo physician. Thus the family is seen as the primary treatment agent of an ill person, even though they may solicit advice and services from persons outside.

Such traditions have definite implications for medical care necessitating hospitalization and probably are directly related to institutionalization of mentally retarded persons by the Mexicano people. Spielberg noted that hospitals are fairly universally regarded among the Latin Americans as places where one goes to die; and, indeed, many Latin Americans do not resort to hospitalization until their illness may be in terminal stages. As described above in connection with pregnancy, the hospital is seen as a very alien environment with strange rules and practices which the *Mexicano* may not understand (Spielberg, 1959). When this is complicated by the fact that many hospitals in South Texas view their mission as converting *Mexicanos* to modern Anglo medicine by exhortation and ridicule (Fantini, 1962), it is not difficult to understand why the services of the hospital are not more frequently sought by the Latin Americans.

There is some evidence that this fear of hospitalization and what might be conjectured to be a concommitant reluctance to utilize institutionalization for mentally retarded persons exists throughout the *Mexicano* culture. Spielberg studied responses to proposed hospitalization for the treatment of tuberculosis among the Latin Americans, defining as an "appropriate response" their voluntary submission to hospitalization. He found that "appropriateness of response" was not directly correlated with the degree of acceptance of folk medical culture but was highly inversely correlated to the degree to which the patient was integrated into the nuclear family. Thus in closely knit and well-integrated families, cultural proscription would seem to preclude hospitalization and institutionalization of ill or handicapped members of the family (Spielberg, 1959). If true, this would present interesting consequences for any studies of Latin Americans in institutions, since this would presumably be a sample biased by a preponderance of subjects from disorganized, disrupted families. Any measure of social deprivation of such children would then be questionable in its representativeness.

Another interesting reaction to the problem of mental retardation is the sort of ambivalence alluded to above which the *Mexicano* might have in attempting to remedy the problem. The consensus of the numerous studies of health practices (Clark, 1959; Fantini, 1962; Madsen, 1964; Rubel, 1966) seems to indicate that while the *Mexicano* may be fatalistic and at times accept the condition as inevitable and irreversible, he may at the same time, without any inconsistencyin his mind, proceed from a doctor to a *curandero*, utilizing a wide variety of remedies. Fantini felt that in cases where a cure appeared to be hopeless, "the 'Mexican' is more prone to make a vow to the Almighty rather than to continue in his own attempt to cure" (Fantini, 1962). Langerhans studied special education in Mexico and found that, in general, the attitude of parents and society toward mentally retarded children was one of pitiful charity, with no concept of training to become useful members of society (Langerhans, 1959). This, when considered with the family context in which the illness is viewed as described above, lends even more support to the conjecture that well-integrated Mexicano families would be reluctant to institutionalize their mentally retarded children. In their frame of of reference, if nothing can be done, the institution would be seen solely as providing custodial care for an apparently unwanted child. They would tend not to view institutionalization as a resource for training and improvement.

Summary

In summary, one can infer that there is relationship between some of the aspects of Latin-American culture as it exists in South Texas and the incidence, treatment, and acceptance of the condition we call mental retardation. Certainly the consequences of the many cultural beliefs and attitudes regarding medical care, especially for expectant mothers and during the delivery of infants, are apparent. Treatment of childhood diseases which may develop complications related to mental retardation is also influenced by cultural beliefs and practices, including theories of the cause of disease and utilization of *curanderos* as healers. The strong family cohesion which exists in the majority of *Mexicano* families has many implications for hospitalization of expectant mothers, ill children, and institutionalization of mentally retarded children. The fact that these practices are seen as alien and probably gratuitous helps to explain the fact that proportionately fewer Latin-American children are hospitalized and institutionalized.

Factors of Negro Culture Affecting Mental Retardation

The consensus of most of the literature describing the Negro culture in America is that this culture is basically American and has little other frame of reference. In his major study of the American race problem, Myrdal concluded that, "... in his cultural traits, the Negro is akin to other Americans" (Myrdal, 1944, p. 928). Allen has reported that "The Negro group in America has no distinctive and no peculiar social institutions. It knows only the culture of America, and the points at which its behavior differs can be attributed to external influences such as the social and economic limitations which have been imposed upon it and the resultant inevitable psychological effects of such limitations" (Allen, 1957). This identification with American culture is not accidental but appears to be the universal motivation of most members of the Negro group. According to Manning, the Negro wants to belong; and his institutional and cultural traits are similar to the corresponding group in the Anglo society. He wants to adopt and has adopted the way of life of the Anglo group as he perceives it and to the extent that he is allowed to do so (Manning, 1960).

Despite this basic identification with American culture, there are many significant ways in which Negro practices and cultural patterns are different from the larger Anglo society. Chief among these is the widespread instability of many Negro families. Reports from public welfare agencies show that public assistance under the A. F. D. C. program has an overly large proportion of Negro recipients. It is also known that almost a fourth of Negro families are headed by a woman, and nearly one-quarter of all Negro births in the nation are now illegitimate. About one-third of all Negro children live in broken homes. These and many other facts emphasize the problem that contrary to the stability achieved by most Anglo families in America, Negro family structure appears to be highly unstable in too many instances; and in a large number of cases, the family structure has broken down.

Frazier has traced the cultural heritage of Negroes and has indicated that the process of destruction of the African family system began in Africa. The relocation of Negroes on relatively small plantations and farms provided them with little opportunity to continue their ancestral culture. Marriages and mating became subject to control of white masters, so that the resulting family system was dependent upon the requirements of a slave system. Frazier points out that in many instances the slave family acquired considerable stability, with the process of assimilation beginning with household servants and gradually working its way to the others. The Civil War and Reconstruction disrupted this established system, and only a few families had the stability to continue as such.

Frazier continues by pointing out that the Negro then began to develop a rural folk family life; and he suggests that among the lower class, which today comprises between 60 and 70 percent of the Negro population, family relations still reflect the influence of these rural folk traditions. But many

Negroes were beginning to move to large communities, so that by the time of the beginning of World War II nearly half the Negro population of the United States was located in large metropolitan areas. It has been difficult, if not impossible, for most Negroes to transplant their rural folk family life background into their new city environment (Frazier, 1948).

It would seem safe to conclude that much of the problem of family breakdown described above has as its cause the difficulties encountered by Negroes from a rural environment in striving to adapt themselves to urban living. Data presented in the preceding chapter indicates that in Texas the Negro still suffers relative poverty, and data in subsequent chapters will outline other problems experienced by Negroes which complicate their adaptation to the larger, Anglo-dominated middle-class system of values.

One interesting point made by some writers is that even though some Negroes have successfully adapted and do identify with middle-class values, they are constantly affected by the problem of continued association with other Negroes who have not been so successful in their adaptation. Frazier indicates that approximately 25 to 30 percent of the Negro population can now be classified as middle class, and he points out that it is this middle-class Negro group which has stabilized and adapted to conditions of city life and which has identified most closely with Anglo middle-class values (Frazier, 1948). Because of factors such as housing segregation, however, it is very difficult for this stable group to escape from the cultural influences of the less stable majority. Middle-class Negro children are constantly being exposed to the pathology that is so widespread in Negro communities and are in danger of being drawn into it.

There are many implications of this discussion for social agencies, including those dealing with the problem of mental retardation. Manning has indicated that the middle- and upper-class Negroes closely identify with the values of the Anglo middle and upper classes and, therefore, present no unique problems to social agencies. He points out that they, as the Anglos, view organized charity in the worst sense of the word. Manning further points out that there are many psychological and cultural resistances in obtaining services traditionally viewed by the public as being for the "down-and-out." More important, however, Manning continues that regardless of the socioeconomic level, Negroes tend to bring their suspicions to social agencies, which they may view as an instrument of white domination. Often there is a problem of communication between agencies and Negro clients, particularly those coming from lower-class backgrounds. The clients may be unaccustomed to a middle-class vocabulary and may lack understanding of the expectations of the professional staff, which may create a passively expressed hostility. Manning feels that Negroes' failure to use agency services, in addition to the reasons indicated above, is many times due to ignorance of the services that are available. Complicating this problem is the fact that many Negroes feel considerable resignation toward problems that they have, and most agencies are not sufficiently aggressive to help them overcome these feelings (Manning, 1960).

Suchman made the same points in his study on medical deprivation. His study indicated that cultural values were found to affect both the perception and interpretation of symptoms and the seeking of medical treatment. He further stated that among the low-level socioeconomic group, medical deprivation is characterized by narrow health horizons, a low level of aspiration concerning preventive care, and a low level of expectation of avoiding disease (Suchman, 1965).

Summary

The Negro culture can perhaps be described as one which is undergoing much change. As Negroes move from a rural setting to an urban environment their cultural patterns and traditions may no longer be appropriate, and the difficult development of new cultural patterns has often been accompanied by the breakdown of family structure and many other social problems. Some Negroes have achieved stability and, in the process, appear to have identified rather closely with the predominantly Anglo middle-class system of values and attitudes. For those who have not, social agencies must recognize the often confusing complex of cultural influences and strive to combat the feeling of hopelessness which so often characterizes the lower-class Negro.

Report of Group Meetings Concerning Cultural Differences of Negro and Latin-American Groups of Texas

To help identify attitudes, reactions, and perceptions of the problem of mental retardation in Texas' minority ethnic groups, three meetings were held with specialists from community welfare and service agencies; many of the group members were themselves leaders of the ethnic groups being discussed. The meetings were very loosely structured; a few questions had been prepared in advance, but the discussion was generally freewheeling (see Appendix for questions). One meeting to discuss the Negro ethnic group was held in Austin; two meetings were held to discuss the Latin-American group, one in Corpus Christi and the other in San Benito. A third field trip was made to several West Texas cities to determine whether or not major regional differences existed.

Report of the Latin-American Group

The two meetings of welfare and service agency personnel concerned with the problems of the Latin-American group are summarized together in the following paragraphs. Although both groups were generally in agreement, the group in San Benito, which is in the Rio Grande Valley, tended more to feel that there were some differences in the way Latin Americans reacted to the problem of mental retardation than did the group in Corpus Christi. This difference may be coincidental, or it may possibly indicate that within one ethnic group there may be regional variations in cultural patterns. The Rio Grande Valley is immediately adjacent to Mexico, and there is much communication and constant movement of people from both countries back and forth across the border. It is possible then that there is a more distinct cultural atmosphere among the Latin Americans here than in Corpus Christi, 150 miles removed from the border, where the group felt that cultural differences were less significant.

Many different areas of concern were represented at the meetings. As an example, the meeting in Corpus Christi was attended by 13 persons: five welfare workers, two ministers, two vocational rehabilitation counselors and the director of Goodwill Industries, one public health nurse, and two physicians--one the director of county public health services, the other a psychiatrist responsible for the mental health division of the City-County Health Department. Of the 13, seven were themselves Latin American, six were Anglo.

This group seemed to be of the opinion that there were no real differences that would distinguish the Latin-American ethnic group from any other in regard to perception and feeling about the problem of mental retardation. A few tentative, subtle differences were advanced, but these were advanced hesitantly and were generally challenged by some of the other members of the group. For example, it was conjectured by one or two of the members that the similarity of response of persons of this group to that of the Anglo group was dependent upon the degree of Anglicization of the Latin Americans; thus those most unacculturated to the Anglo system of values would be less likely to, for example, institutionalize a retarded child. This thesis was fairly generally accepted, but the premise that it was uniquely Latin American was challenged, with the point being made that various subgroups of the Anglo ethnic group and the Negro ethnic group might also be called "unacculturated," and that they would also likely respond in this same manner.

Another tentative thesis advanced was that there might be some difference in response according to age; it was felt that acculturation to Anglo standards was generally closely correlated with economic levels among younger persons, but that some older persons tended to cling to "the old ways" regardless of their income level.

This idea was corroborated by an example given by a Latin-American professional person in one of the groups, who admitted that her daughter had been treated by medical specialists for epilepsy. The girl's grandparents, who were well-educated, respected, upper middle-class members of the community expressed doubt at the medical treatment and treated the child by having her jump three times over a broom handle and a candle placed together on the floor.

This example could tend to confirm the belief that older persons might respond differently to the problem than younger, more acculturated persons. This idea was rather insecurely accepted by the group, but was attacked on the premise that the social mores and values with which this was being contrasted were of the predominantly younger Anglo society, and that older persons of any ethnic group might tend to hold to old ways of looking at problems and dealing with them.

One group indicated that the low socioeconomic group is more apt to relate illnesses of all kinds to folk beliefs. One member related that recently a friend had not gone to a funeral because his fingers were cut and bandaged, and he feared that the fumes of the corpse would enter the cuts, and he would die of the same cancer that had caused the friend's death.

Concerning the acceptance of the mentally retarded child in the community, the group pointed out that the term "mental retardation" was relatively new to their language and understanding. They indicated that the mentally retarded child, called tonto (stupid), is generally sympathetically accepted, but the mentally disturbed child, loco (crazy), was not so readily accepted. Some stigma is attached to locos, and the group indicated the need for an educational campaign to explain the difference between the two problems. They pointed out that the trainable mentally retarded child is very often mistakenly categorized as loco.

A possible difference most securely advanced, but by no means accepted unanimously, was the idea that regardless of acculturation, economic level, educational level, or any other factor, there was a slightly higher degree of family cohesiveness among Latin Americans in general which would tend to exert a little more pressure on families with retarded children to keep them at home. While this idea was generally accepted, it was stressed by several of the members that this should not be overly exaggerated, that family disorganization was common, particularly at the very low income level, in the Latin-American group just as it was in other groups. They felt it would be more appropriate to think of this difference more in terms of degree rather than substantive differentiation of this ethnic group.

Conversely, many different opinions were advanced to the effect that there were no differences in how the problem of mental retardation was perceived by the Latin-American ethnic group or in their attitudes toward it. It was, of course, recognized that these feelings and attitudes are very strongly affected by educational and economic level, but many of the persons in the group felt that there were no cultural differences in feeling or attitude about the problem.

The most important point to emerge from the meetings, however, was the very strong feeling of the groups that there were many differences in services provided to the Latin-American group and in their utilization of these services. Specificially, it was felt that many agencies serving the retarded were not adequately prepared to meet the needs of the Latin-American ethnic group because they were not able to adequately communicate with them. One idea stressed over and over again by the group was that social agencies had to have more staff persons who were themselves Latin American and therefore able to communicate. The question was asked whether the staff members would have to be Latin American or only able to communicate with Latin Americans; the answer was generally unanimous that anyone who could communicate, be he Latin, Anglo, Negro, or whatever, could do the job, although it might take him somewhat longer to communicate his sincere interest and concern in the Latin-American family with the problem. It was felt that the most important thing, however, was his desire to help and his ability to communicate, and that these were sufficient regardless of his ethnic background.

Summary

In summary, it was the feeling of these two groups that the Latin-American person would have the same feelings and attitudes toward his having a mentally retarded child that any other person of any other ethnic group would have. It was recognized that his feelings and attitudes, and even more his response to the problem, would be affected by his understanding of the problem, which in turn would probably be dependent upon his educational level and highly correlated with his economic level. It was stressed rather strongly at the Corpus Christi meeting, however, that there were no major differences in the feelings or attitudes of people of any ethnic group, and that in this regard the Latin American would be no different from any other person.

As mentioned above, it was felt conversely that there were many differences in the services offered to this ethnic group and in their utilization of these services, with the general trend being toward much poorer service for the Latin American than for some others.

Report of the Negro Group

The third meeting, concerned with the Negro ethnic group, was held in Austin and was attended by 11 persons, all of them Negro. Of these 11, two were welfare workers; one a vocational rehabilitation counselor; five from education, including two special education persons, one regular teacher, and two school principals; one minister; one physician in public health; and one representative from the state Office of Economic Opportunity. In this meeting, the discussion was likewise very freewheeling and only very loosely structured by the questionnaire.

In the Negro group, too, the idea seemed to be prevalent that there are no differences in the feeling or attitudes of persons toward a mentally retarded child in their family. Here again, there was the strong idea advanced that the attitudes of people were significantly affected by their understanding of the problem, which in turn depended on their education and was correlated with their economic condition. But it was felt that this was not a basic ethnic group difference and that the total range of responses would exist within any ethnic group.

The idea was tentatively advanced that there might be some tendency toward keeping the child at home, with a "this is my burden to bear" attitude on the part of the family. This idea was not generally accepted as a very fundamental and basic difference existing in this ethnic group, although several persons did tend to feel that there might be a somewhat stronger feeling of this kind in the lowest socioeconomic group of Negroes than in other ethnic groups. This idea was challenged, however, by the idea that the most severely disadvantaged persons simply lack motivation to do anything about their problem; that is, their compounded frustation causes them to be somewhat more resigned to this and other problems and therefore less prone to do something about them, a characteristic which would not be unique to this or any other cultural or ethnic group.

The entire discussion seemed to echo that of the Latin-American group that, basically there are no major differences in personal feelings or attitudes about the problem of a mentally retarded child among persons of different ethnic groups. However, as in the Latin-American group, it was felt by the Negro group members that there was considerable differences in services provided to Negroes and their utilization of these services.

The group felt that the lingering effects of segregation, and the hold-over effects of previous segregation accounted for some of this difference. It was pointed out that the state institutions for the mentally retarded were formerly very strictly segregated, with all Negroes living in segregated units. Although this has not been the case for several years, it was surprising to learn that some professional personnel in this group were not completely aware of the extent to which integration had been accomplished, and they used this to very graphically illustrate the fact that members of the lay Negro community would be even less aware of the fact that this change had taken place. Likewise in other areas of service, it was noted that feelings engendered among Negroes as a result of past practices of segregation were still significant in affecting their attitudes toward services. The ramifications of segregation seemed to be the most significant aspect of the discussion of the Negro group. They indicated that services for the retarded and the Negroes' utilization of these services were affected by ingrained feelings toward past injustices.

One of the recommendations of the Negro group was the need for much more public education about the problem of mental retardation and the resources which exist for it. They expressed the need for more Negro staff persons in social agencies to aid in communicating to Negro families the availability of resources for help with this problem. Other suggestions, such as transportation to special education classes, transportation of rehabilitation clients to their jobs, and other general recommendations, seemed to be not significantly different from those made by many groups in the Texas Mental Retardation Planning Study and appeared to be not especially related to the Negro ethnic group as opposed to any other.

In summary, the same attitude seemed to prevail among the Negro group as among the Latin-American groups--that human feelings and attitudes of any parent toward a handicapped child transcend ethnic group lines, but that provision of services by society and utilization of services is very obviously different among the different ethnic group populations.

It would, of course, be a mistake to assume that this is a definitive and unassailable answer to the question of the existence of differences in attitudes, feelings, and reactions of different ethnic groups to the problem of mental retardation. The true picture may yet remain to be discovered.

CHAPTER IV

DEPRIVATION AND MENTAL RETARDATION

It might be concluded from the material presented in the previous chapter that while cultural beliefs and traditions may have some influence on a family's reaction to the problem of a mentally retarded child, there is no basic difference in the feelings and attitudes that can be attributed to ethnic group differences. This should not obscure the fact that many factors which characterize minority ethnic groups are very significantly related to retardation. Such factors as low income, poor health, low educational achievement, and the resultant complex of poverty have been shown in many studies to be major factors in the causation of mental retardation. These problems are not inherently characteristic of any ethnic group, but unfortunately they are so frequently associated with Negroes and Latin Americans in Texas that the study of Texas' minority ethnic groups' problems is largely the study of the socially and economically disadvantaged.

In this and subsequent chapters the extent of this disadvantage and the primary role it plays in causing mental retardation among Texas Negroes and Latin Americans will be elaborated. Rather than the culture *per se* of Latin Americans and Negroes, it is this culture of poverty which holds the secret and the key to the problem of mental retardation among Texas' minority ethnic groups.

Statistics presented in Chapter II on the subject of economic level and figures presented in Chapter V on health conditions indicate that in both of these areas, Negroes and Latin Americans of Texas fall significantly below the standards of the Anglo group. Educational statistics cited in the first part of Chapter I also indicate that children from the two minority ethnic groups are more likely to come from homes of functionally illiterate parents. All of these factors imply that many Latin-American and Negro children in Texas can be described as socially disadvantaged or culturally deprived. In addition to these factors of abysmal poverty and low educational level of parents, these children's lives are also characterized by poor diet and poor health practices.

Studies in Deprivation

Havighurst described the socially disadvantaged child as one who is at the bottom of American society in terms of economic status, who also suffers from social and economic discrimination by the majority of the society. Other recent studies have clearly shown a close relationship between poverty, concentration of ethnic minority groups, social isolation, and cultural deprivation (Havighurst, 1965; Bloom, Davis, Hess, 1965; Clapp, 1966).

The effect of cultural deprivation on intellectual functioning has received some attention in the past and is receiving a great deal of attention at present. Studies by Pasamanick, Speers, and many others have shown that excessive lack of mental stimulation can lead to inefficient use of native intelligence, which, protacted through the first nine or ten years of a child's life, can result in relatively permanent deficiency in intellectual performance (Pasamanick, 1946; Speer, 1940). Studies by Clarke, Skeels, and Skodak, among others, have shown, however, that intervention at an early age can not only arrest the process of deterioration in intellectual functioning, but can reverse it with a resultant increase in measured performance (Clarke, et al, 1958; Skeels, 1941-42; Skodak and Skeels, 1949).

Clarke and Reiman (1958, pp. 144-157) studied the effect of environmental changes on intellectual functioning of mentally retarded persons. Earlier studies by the authors had demonstrated substantial increases in the measured intelligence of retarded persons removed from extremely impoverished environments. Their study indicated that retarded persons from extremely impoverished environments had positive gains in intelligence test scores when they were removed to a richer environment. Retardates from the most impoverished environments made the greatest gains in test scores as a result of the change.

Kephart's (1940, pp. 223-230) study of the effects of environmental stimulation on the rate of mental growth in retarded children indicated that 16 boys who participated in a special training program showed an average gain of 10.1 points in intelligence test scores during the period of their participation in this study. Pasamanick's (1946, pp. 3-44) study of behavioral development of Negro infants showed that the behavioral development of the selected groups of institutionalized white children was influenced by environmental impoverishment. Pasamanick indicated that lack of environmental stimulation contributed to a downward trend beginning at the third year of life for Negro infants.

Skeels' (1941-1942, pp. 340-350) study of the effects of environmental stimulation of mentally retarded children demonstrated the positive effects upon his study groups when they were removed from impoverished environments. Skeels attributed the deterioration present to prolonged exposure to impoverished environments. Skodak and Skeels' (1949, pp. 85-125) follow-up study of 100 adopted children indicated that the children removed from their previous environment had a mean I. Q. level 20 points higher than measured intelligence of their true mothers. The study indicated that the intellectual functioning level was compatible with the environment in which the children were placed. Speers (1940, pp. 309-314) studied the mental development of children of retarded parents and found a direct relationship between adverse environmental conditions and deterioration in level of intellectual function.

The overwhelmingly unanimous conclusion from all of this material is that severe deprivation, if not prevented, can cause mental retardation. Data cited above has certainly indicated that many Latin-American and Negro children in Texas can be characterized as culturally disadvantaged or deprived, and thus subject to this complexity of factors resulting in a severe deprivation of intellectual stimulation. One might safely conjecture, then, that there are many cases of deprivation-caused mental retardation among these children, and the statistical preponderance of their enrollment in special education classes is confirmation of such a conclusion.

Complicating the problem for many minority group children is difficulty with language. Most of the Latin-American children in Central and South Texas grow up speaking Spanish in their home and are, therefore, not prepared to achieve very successfully in an English-oriented school program. Their inadequate English vocabulary and the slowness in their thinking caused by translation from one language to another may often cause further problems. The speaking of Spanish cannot be construed as a phenomenon of deprivation, but the many obvious difficulties caused by a lack of knowledge of the language in which school classes are being conducted would understandably compound any other problems already present. With this in mind, and with the assumed correlation between poor knowledge of English and poor environmental conditions, it can be safely assumed that the "language problem" is an influential factor in compounding problems of deprivation which lead to mental retardation.

Another facet of the problem necessitates a differentiation between cultural difference and cultural deprivation. There are many aspects of the Negro culture of East Texas and more especially of the Latin-American culture of South Texas which are, superficially at least, different from the predominant Anglo culture. Unfortunately, these differences are all too often excoriated rather than valued by such representatives of the Anglo society as school teachers, law enforcement officials, and welfare workers.

While it would be a gross error to misinterpret cultural differences as cultural deprivation, there is a possible area in which this may create a problem. Most of the definitions of cultural deprivation stress the necessity for experiences which provide the child with learning models. To the extent that the experiences (and therefore the learning models) of a child from a minority group are different from those of children of the majority group, one might expect the minority group child with different learning models to be handicapped slightly in transferring knowledge and concepts from those situations which he has experienced to new ones which are not within his general cultural frame of reference. While many children may be able to make such transfers of association without too much difficulty, it can be assumed that this, too, would compound any other difficulties a child might already have. Thus, another factor in the complex of problems of language and cultural deprivation might be that of the difficulty of transferring concepts of learning from one cultural model to another.

CHAPTER V

HEALTH FACTORS AND MENTAL RETARDATION

It is clear from the literature and data reported in this study that the proportion of economically, socially, and culturally disadvantaged persons in the Negro and Latin-American ethnic groups of Texas is significantly higher than in the Anglo or total Texas population. Commenting on the relationship of socioeconomic disadvantage to mental retardation, Robert E. Cooke, M. D. reported, "Low socioeconomic group is one of the factors which is positively correlated with increased frequency of defective infants." Cooke indicated that it is "an epidemiologic fact that wherever general socioeconomic conditions and prenatal care are better, the frequency of mental retardation is less." He further reported, "Mothers ... from poor socioeconomic circumstances in their early lives have much higher rates of prematurity as well as more complications regardless of factors in the current pregnancy." Cooke stated, "The provision of an adequate environment early in life to the potentially mildly damaged may well minimize significantly his future handicap" (Cooke, 1964, pp. 98 and 101).

In the same report, Proceedings of the White House Conference on Mental Retardation, Robert A. Aldrich, M. D. stated, "No doubt exists that there is a relatively high occurrence rate of mental retardation among prematurely born infants" (Aldrich, 1964, p. 82). Aldrich reported that better nutrition, prenatal care, and family counseling about genetics and management of complicated pregnancies would effect significant reduction in the number of premature, and thus mentally retarded, infants. Although the specific effects of diet in the prevention of prematurity have not been absolutely established, there is evidence that general improvement in dietary habits of pregnant women leads to a reduction in the incidence of premature birth which in turn leads to fewer retarded and otherwise handicapped children.

John B. Thompson, M. D., at the same conference, made the following recommendations concerning the quality of human reproduction. He suggested that the nation (a) develop a strong research effort into the causes of mental retardation related to pregnancy; (b) develop methods for prevention and treatment of these causes of mental retardation related to pregnancy; (c) develop programs of adequate maternity care, especially for the high-risk indigent groups of expectant mothers; and (d) give top priority to the study of the quality of human reproduction.

The report of the Task Force on Prevention from the President's Panel on Mental Retardation forcefully proposed that vigorous and effective application of present medical knowledge could significantly reduce the occurrence of mental retardation. The Task Force felt that the high incidence of causative factors and the enormous cost of a lifetime of care justified the expenditure of large sums for prevention on economic grounds alone. It was indicated that biological prevention offered increasingly broad horizons for widespread application. Improved obstetrical practices has avoided some cases of mental retardation due to anoxia, mechanical, and other injury to the brain during delivery. The Task Force reported on the results achieved in avoiding brain damage associated with blood incompatibilities between the mother and the infant.

The President's Panel report suggested that a revitalized and vigorous effort should be made at national, state, and local levels to make high-quality prenatal care easily accessible to all segments of the population with particular emphasis on the economically and culturally deprived groups. The Panel reported that particularly among the low socioeconomic groups, substantial numbers of expectant mothers received no prenatal care or extremely inadequate health supervision.

The following data gathered on live births, which includes rate of midwife and home deliveries and information relative to cause of deaths, is particularly relevant to the previous discussion and needs little elaboration and interpretation.

Vital Statistics of Texas' Major Ethnic Groups

Live Births

The rate of live births per 1,000 population is more than twice as high in the Latin-American group as in the Anglo and is considerably higher than the rate for the Negro group. Figure 5 indicates that the 1965 live birth rate for Anglos is 16.2; for Latin Americans the rate is 34.3; and for Negroes, 26.4. This relative proportion has remained fairly constant over the 15-year period, 1950-1965. It has been pointed out in Chapter II that the Latin-American population is increasing and continues to grow at a much faster rate than any other Texas ethnic group.

Midwife and Home Deliveries

Midwife deliveries for the three ethnic groups are indicated in Figure 6. This table illustrates that there has been over a 50% decline in the number of midwife deliveries in all three ethnic groups during the 15-year period 1950-1965. The greatest decline has been in the Latin-American group; 28.8% of total live births of this group were delivered by midwives in 1950, but this figure dropped to 10.0% in 1965. Midwives delivered 25.2% of all live births among Negroes in 1950, but only 8.9% in 1965. The rate in the Anglo group has remained relatively constant, and in 1965 was only .02% of all live births.

Although there has been a steady decline in the use of midwives in both the Negro and Latin-American populations of Texas, the significance of the 1965 proportion of such deliveries should not be underestimated. In 1962, for example, in one predominantly Latin-American county, a large segment of the population had little or no prenatal care; and over 50% of the deliveries were made by midwives. In 1962 there were over 10,000 midwife deliveries in Texas, and 10 counties reported that over 20% of all deliveries were made by midwives.

FIGURE 5

LIVE BIRTHS
BY ETHNIC GROUP
1950, 1960, 1965

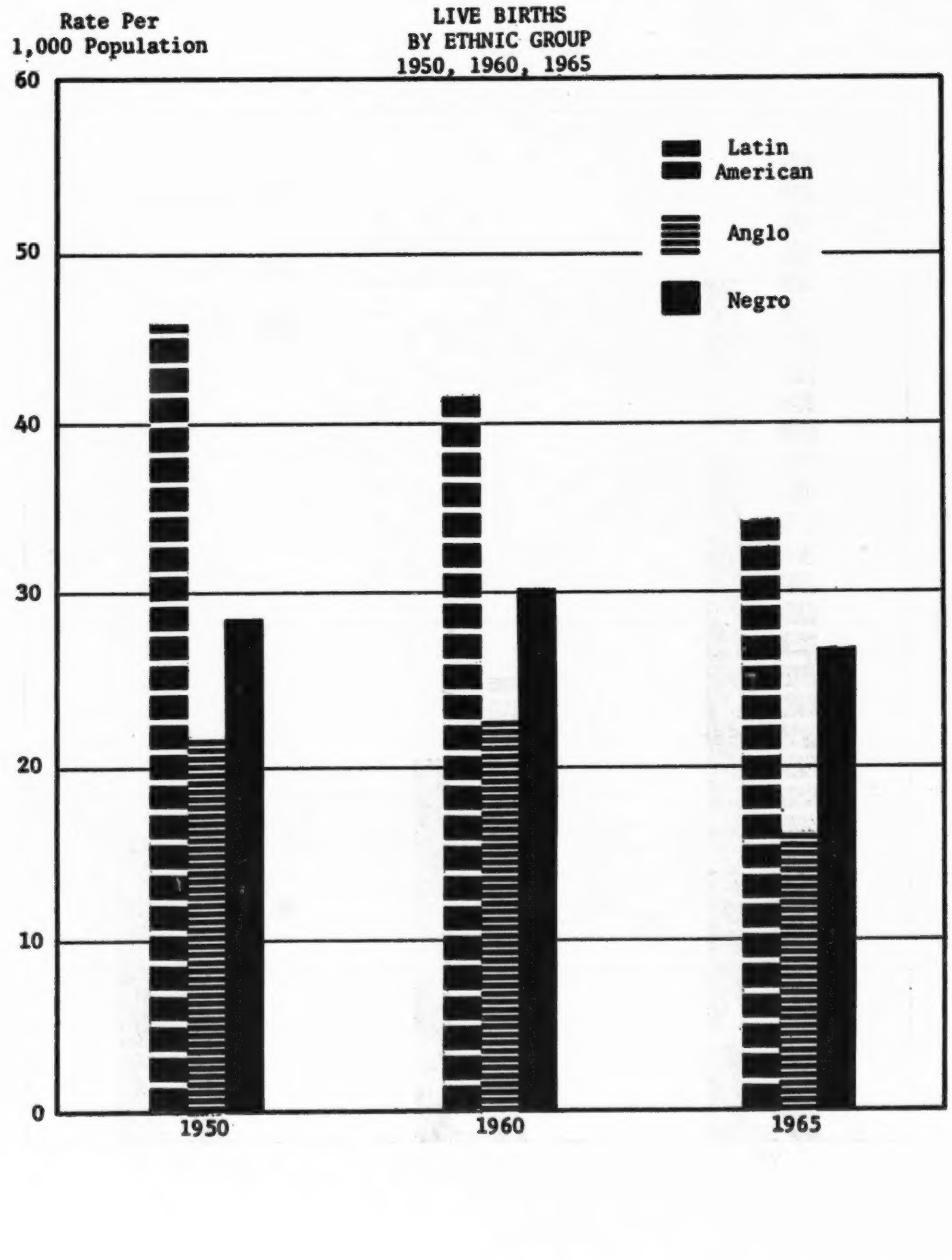
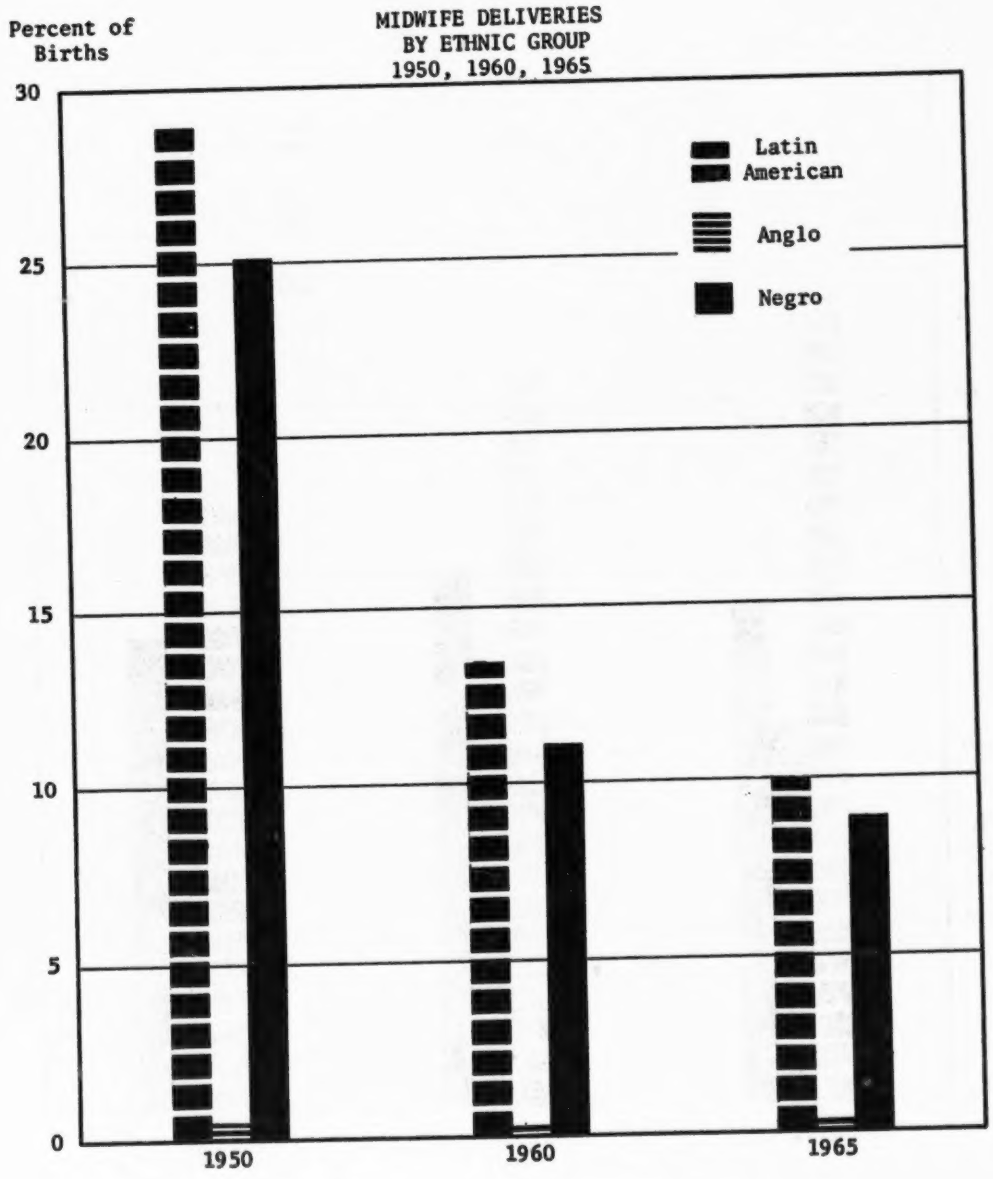


FIGURE 6

MIDWIFE DELIVERIES
BY ETHNIC GROUP
1950, 1960, 1965



During the summer of 1957, James D. Wheat, a medical student, made a study of midwifery in Cameron and Hidalgo counties. He found that the number of midwife deliveries in homes was consistently far above the number of home deliveries by physicians in the city of Brownsville and the rural areas of Cameron County. The midwives handled nearly all of home deliveries in the city of Brownsville for the year 1955 and were responsible for a number of stillbirths in the same city during 1953. He reported that although county records showed that physicians were present and signed death certificates for a large proportion of stillbirths, this was not a true picture of the situation, since many times midwives encountered difficulties in the delivery and called upon the physician at the last moment.

Wheat interviewed a number of midwives in Hidalgo county. Ten of those interviewed had never had any type of formal education. Three had attended school only up to the third grade; two had a fifth-grade education; and two others went through six years of school. Only two of the midwives were educated beyond the ninth-grade level. Wheat noted that charges for deliveries ranged from a low of $12.50 to a high of $35.00 in 1955.

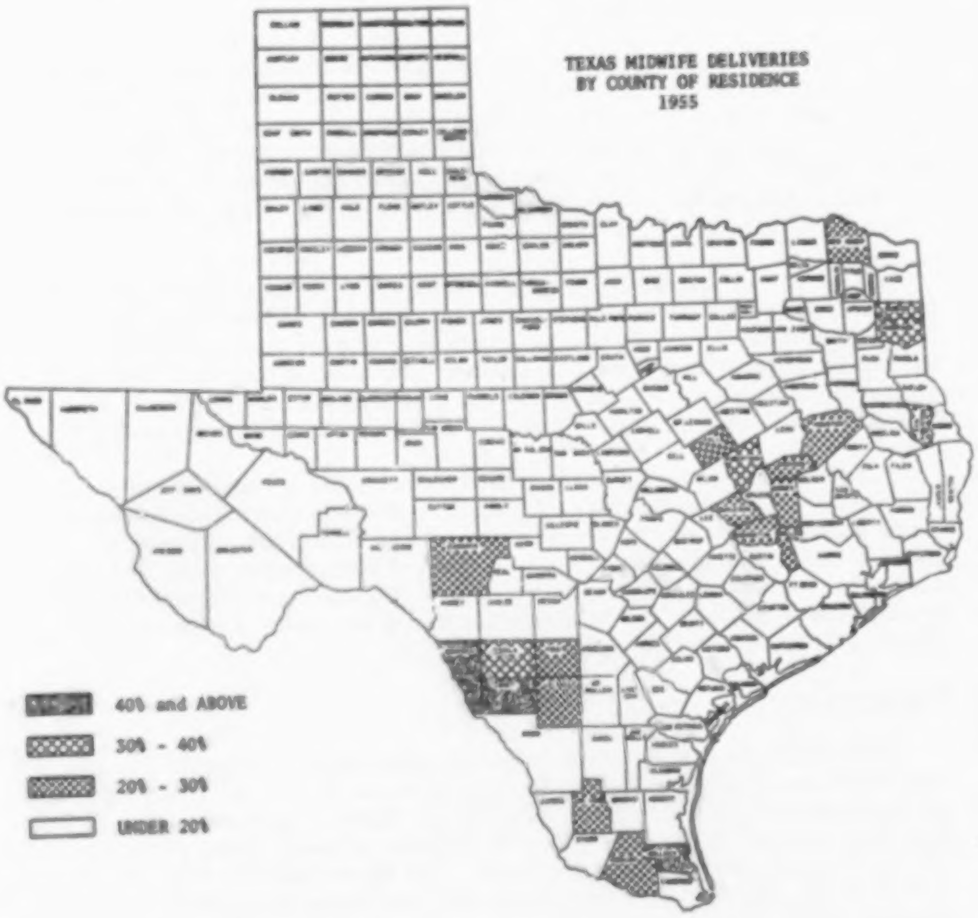
Of particular significance to this study was the fact that Wheat found that of 22 midwives interviewed, nine made no visit in the home before the time of delivery. Three other midwives went to the home prior to the delivery only when it was necessary, and none of the midwives customarily made more than three or four prenatal visits. Figure 7 indicates the percent of midwife delivery by county of residence for the year 1955.

Closely related to delivery by midwives is the number of home deliveries. Figure 8 indicates the decline in home deliveries for all three ethnic groups during the 15 year period 1950-1965. Figure 8 clearly shows that the greatest proportion of home deliveries are in the Latin-American and Negro ethnic groups. Figure 9 and Figure 10 show the decline in midwife and home deliveries in the Latin-American and Negro populations for the period 1948 to 1965.

Prenatal Care

The importance of prenatal care has been demonstrated in the medical literature and is emphasized in the report of the President's Panel on Mental Retardation and subsequent documents. Table 8 presents some rather startling figures on the proportion of mothers of each ethnic group who received no prenatal care whatsoever. The figure was 1.9% for the Anglo; it was 11.4% for the Latin American; and the Negro group was highest with 16.5% receiving no prenatal care. The proportion of women receiving prenatal care in the first trimester was also rather striking. In the Anglo group, 70.4% received prenatal care, but only 36.4% of the Latin-American and only 27.0% of the Negro group received care during the first trimester of pregnancy.

FIGURE 7



TEXAS MIDWIFE DELIVERIES
BY COUNTY OF RESIDENCE
1955

FIGURE 8

HOME DELIVERIES
BY ETHNIC GROUP
1950, 1960, 1965

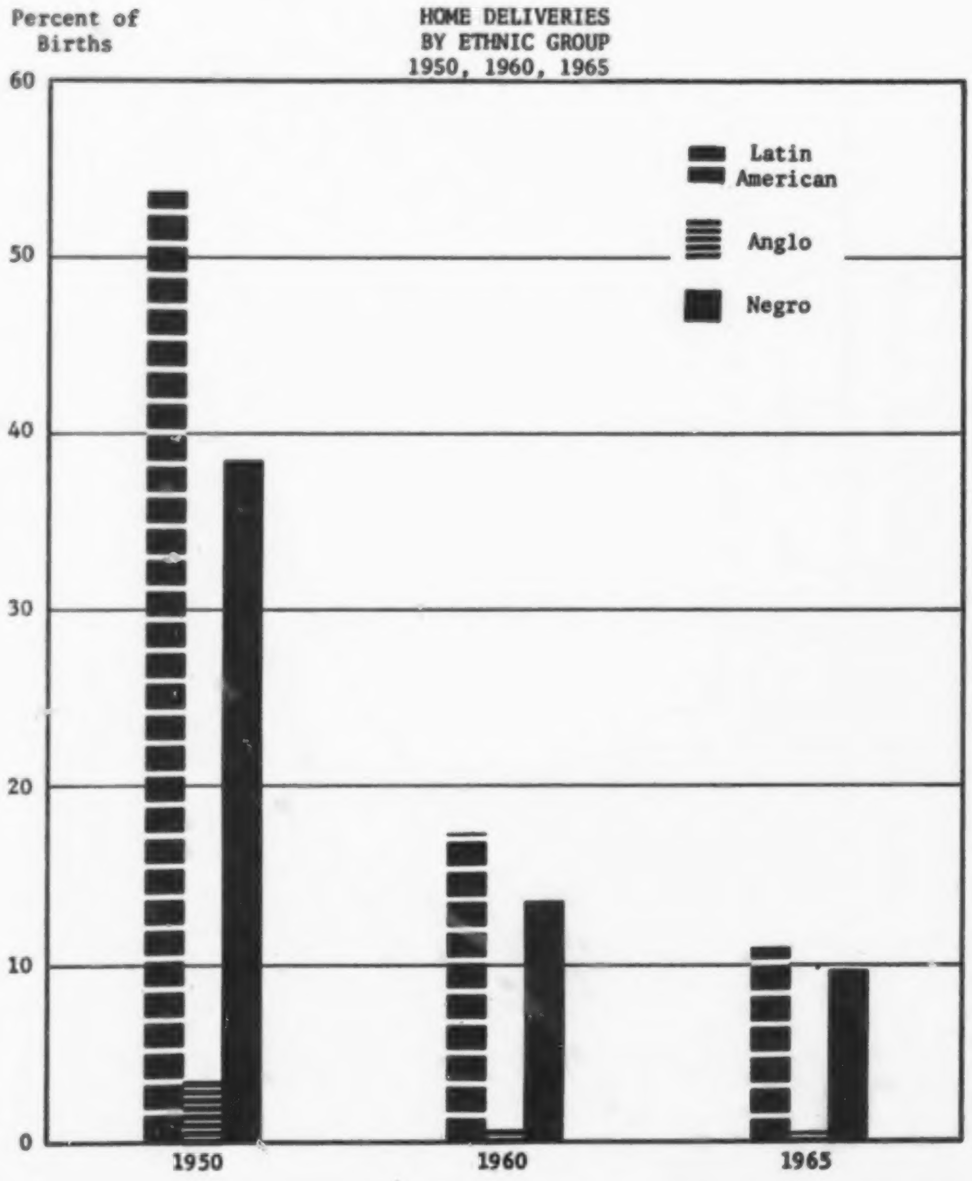


FIGURE 9

MIDWIFE AND HOME DELIVERIES, NEGRO BIRTHS, 1948-1965

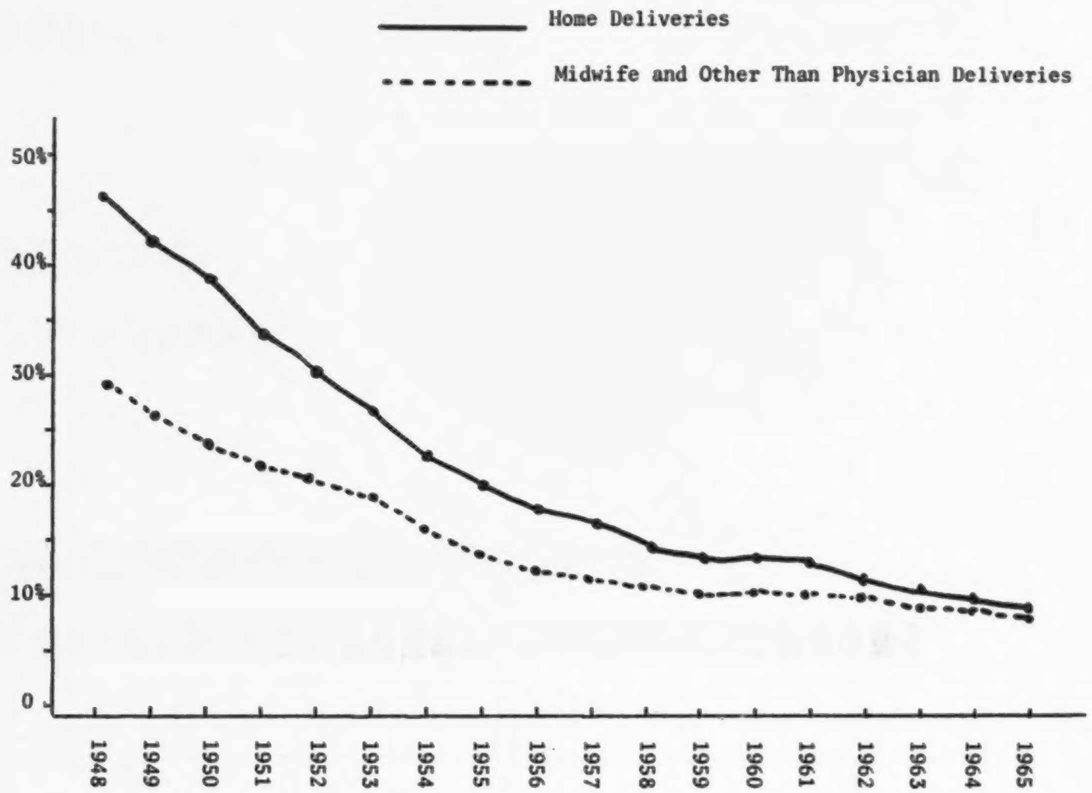
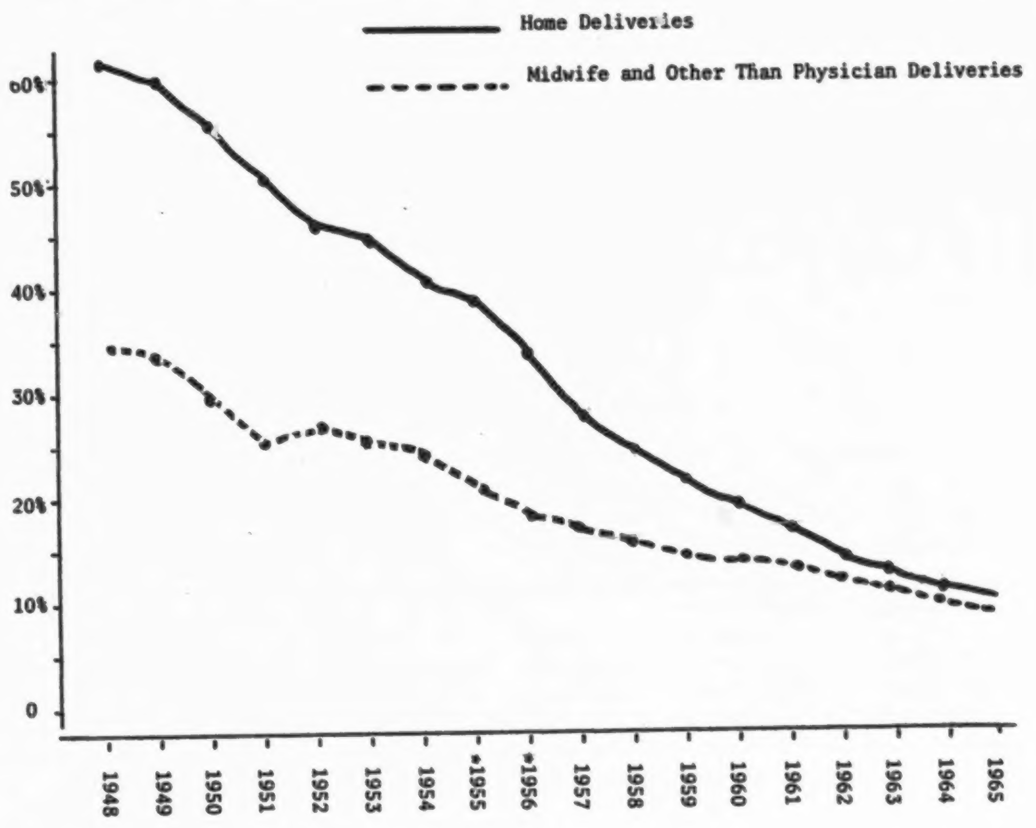


FIGURE 10

MIDWIFE AND HOME DELIVERIES, SPANISH-SURNAME POPULATION, 1948-1965



*Estimated

TABLE 8

PRENATAL CARE IN THREE MAJOR ETHNIC GROUPS OF TEXAS 1965

Ethnic Groups	Total Births	Number With No Prenatal Care	Percent With No Prenatal Care	Number Receiving Prenatal Care 1st Trimester	Percent Receiving Prenatal Care 1st Trimester
Anglo	122,555	2,316	1.9%	86,334	70.4%
Negro	34,552	5,689	16.5%	9,350	27.0%
Spanish Surname	55,171	6,323	11.4%	20,095	36.4%

Infant Deaths

The Negro infant death rate is almost twice that of the Anglo population. The contrast in the three groups is pointed out in Figure 11. For the year 1965, the Anglo rate was 20.8 deaths per 1,000 live births; the Latin-American group rate was 28.2; and the Negro group rate was 41.6 Figure 1 points out the sharp decline in infant death rate in the Latin-American population between 1950 and 1960. Although there has been a decline in the Negro infant death rate over the same period, it has not been as striking nor as great as that of the Latin-American population. The infant death rate in the Anglo population has remained fairly constant during the last five years.

Maternal Deaths

The rate of maternal deaths in all three ethnic groups has remained fairly constant during the last five years. Over the 15-year period 1950-1965, however, there was a dramatic decline in the maternal death rate in the Negro group. There was a smaller decline in the Latin-American and Anglo population. The Latin-American maternal death rate is approximately three times that of the Anglo; and the Negro rate is over four times that of the Anglo population, as indicated in Figure 12.

Deaths From Birth Injuries

Deaths from birth injuries, atelectasis, and postnatal asphyxia are indicated in Figure 13. They have remained fairly constant over the 15-year period 1950-1965 and have remained relatively equal in the three ethnic groups, with the exception of the Negro population which has had a somewhat higher death rate from these causes.

Deaths due to Diarrhea of the Newborn

The death rates for diarrhea of the newborn over the 15-year period 1950-1965 are indicated in Figure 14. Although there has been some change, the ratio has remained relatively constant. In 1965 the death rate per 1,000 live births was 0.1 for the Anglo, 0.4 for the Latin-American, and 0.4 for the Negro populations.

Deaths From Other Diseases of Early Infancy

The death rate per 1,000 live births in 1965 from other diseases of early infancy was 7.1 for the Anglo, 7.1 for the Latin-American, and 14.0 for the Negro population. There has been a decline over the 15-year period for the Anglo, Latin-American, and Negro populations. The rate for the Negro population, however, rose during the five-year period 1960-1965, as is indicated in Figure 15.

Deaths, All Causes

The death rate, all causes, all ages, for 1965 was 8.2 per 1,000 population for the Anglo, 5.3 for the Latin-American, and 9.7 for the Negro population. The Latin-American and Negro populations are both considerably younger than the Anglo population, and this might possibly account for the higher death rate in the Anglo population.

FIGURE 11

INFANT DEATHS
BY ETHNIC GROUP
1950, 1960, 1965

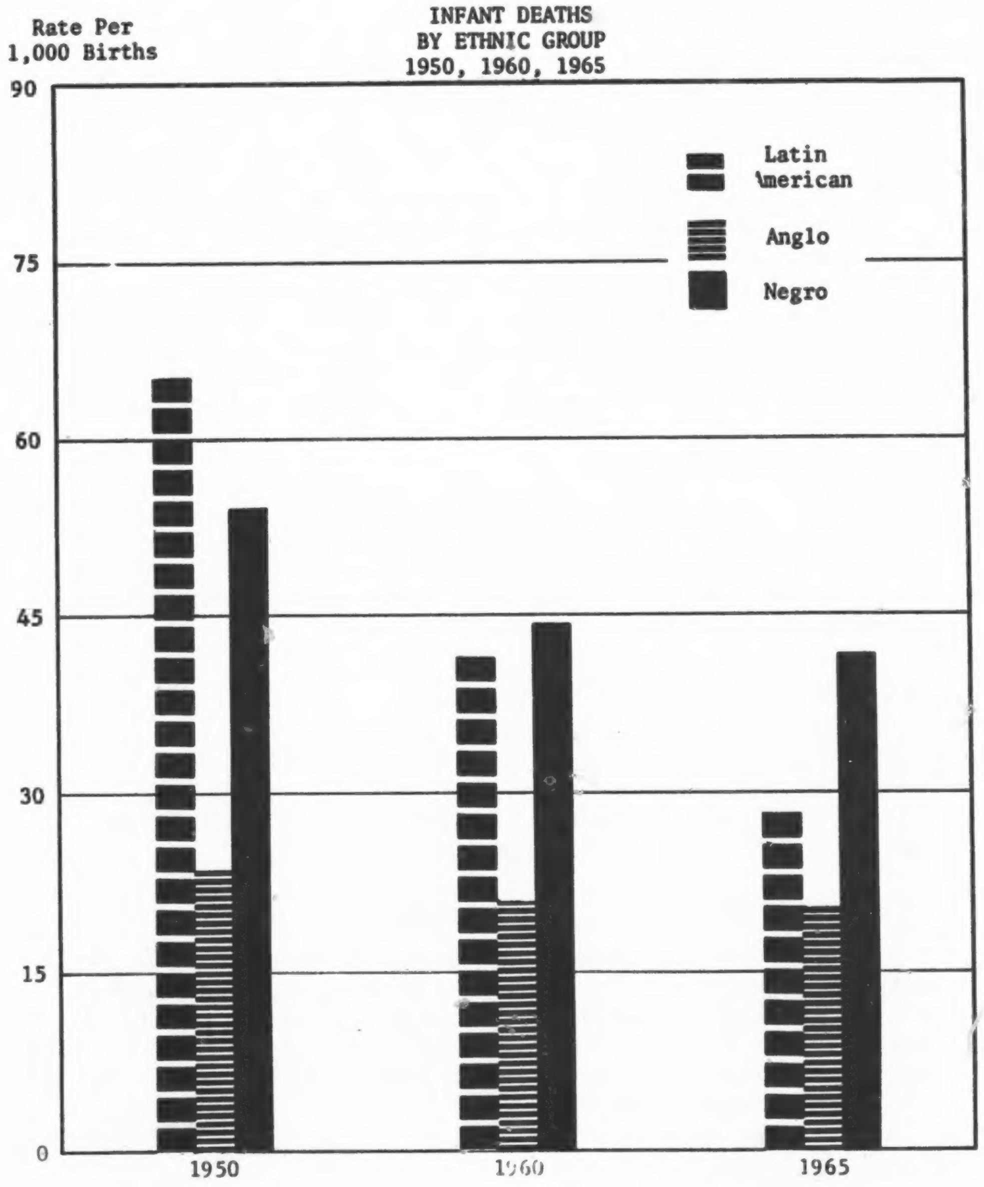


FIGURE 12

MATERNAL DEATHS
BY ETHNIC GROUP
1950, 1960, 1965

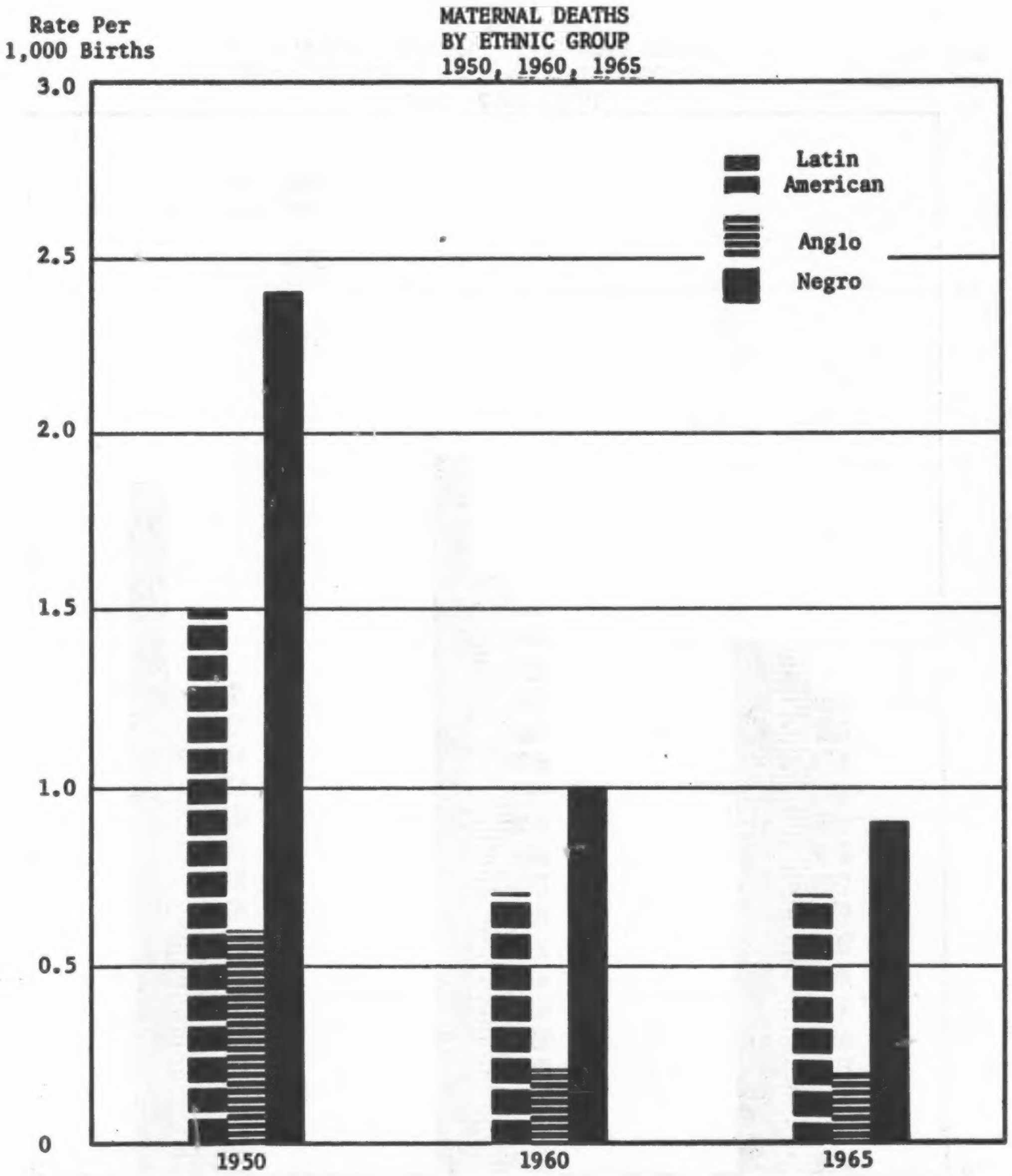
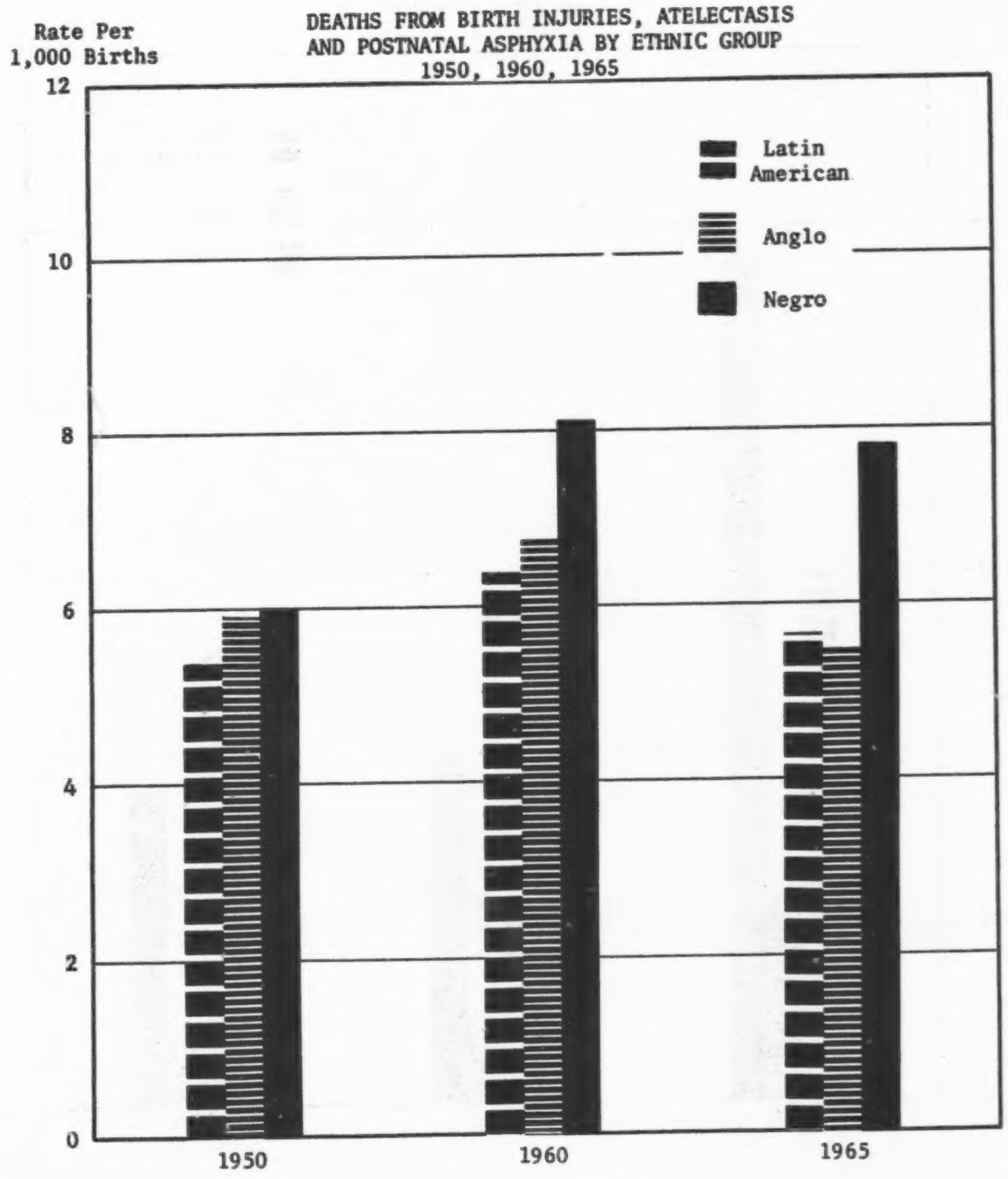


FIGURE 13

DEATHS FROM BIRTH INJURIES, ATELECTASIS AND POSTNATAL ASPHYXIA BY ETHNIC GROUP
1950, 1960, 1965



Deaths From Tuberculosis

Deaths from tuberculosis are indicated in Figure 15 and were included to show the dramatic decline in the death rate over the 15-year period 1950-1965. Again, as in the previous instances, the death rate is higher for the Latin-American and Negro ethnic groups.

Deaths From Dysentery

Deaths from dysentery have dramatically declined in the Latin-American group over the 15-year period 1950-1965, clearly indicating that the efforts of State agencies and county health departments are achieving results. The rate again, however, is dramatically higher in the Latin-American and Negro population (see Figure 17).

Deaths From Gastroenteritis

The death rate from gastroenteritis has dramatically decreased in the Latin-American population over the 15-year period. It remains relatively unchanged for the Anglo group, with some reduction in the Negro population. The death rate in the Latin-American group is more than twice that of the Anglo group, as is the Negro rate. This is indicated in Figure 18.

Deaths From Congenital Malformations

Figure 19, indicating the death rate from congenital malformations, may reflect more adequate reporting during the last few years. In 1965, the death rate per 100,000 population from congenital malformations was 14.7 for the Latin-American, 11.5 for the Negro, and 8.5 for the Anglo population.

Deaths From Infection of Newborn

Both the Negro and Latin-American rate of death from infection of the newborn is over twice that of the Anglo group. There has been a steady decline, however, in the death rate from these causes over the 15-year period 1950-1965.

Key Recommendation No. 4 of the Texas Governor's Advisory Committee on Mental Retardation is particularly relevant to the preceding discussion:

> It is recommended that--in the interest of preventing mental retardation--the Texas State Department of Health strives to provide all expectant mothers, newborn infants, and children with comprehensive health supervision including preventive and treatment services. Expansion, improvement, and establishment of additional facilities for maternal, newborn, and child care should be made by the State of Texas with emphasis on the economically deprived groups (Governor's Advisory Committee on Mental Retardation Planning, State of Texas, 1966, p. 21).

FIGURE 14

DEATHS FROM DIARRHEA OF NEWBORN
BY ETHNIC GROUP
1950, 1960, 1965

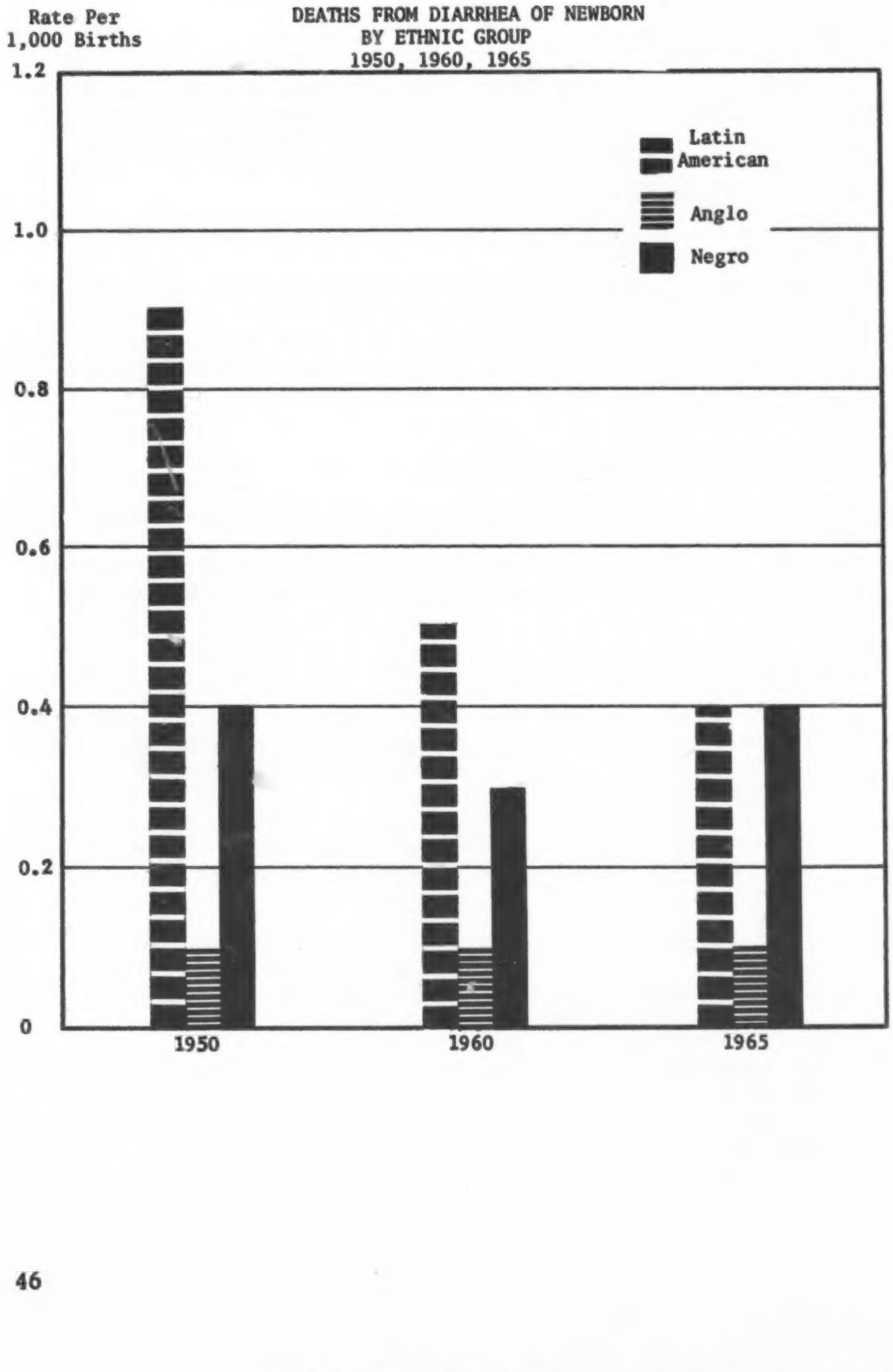


FIGURE 15

DEATHS FROM OTHER DISEASES OF EARLY INFANCY
BY ETHNIC GROUP
1950, 1960, 1965

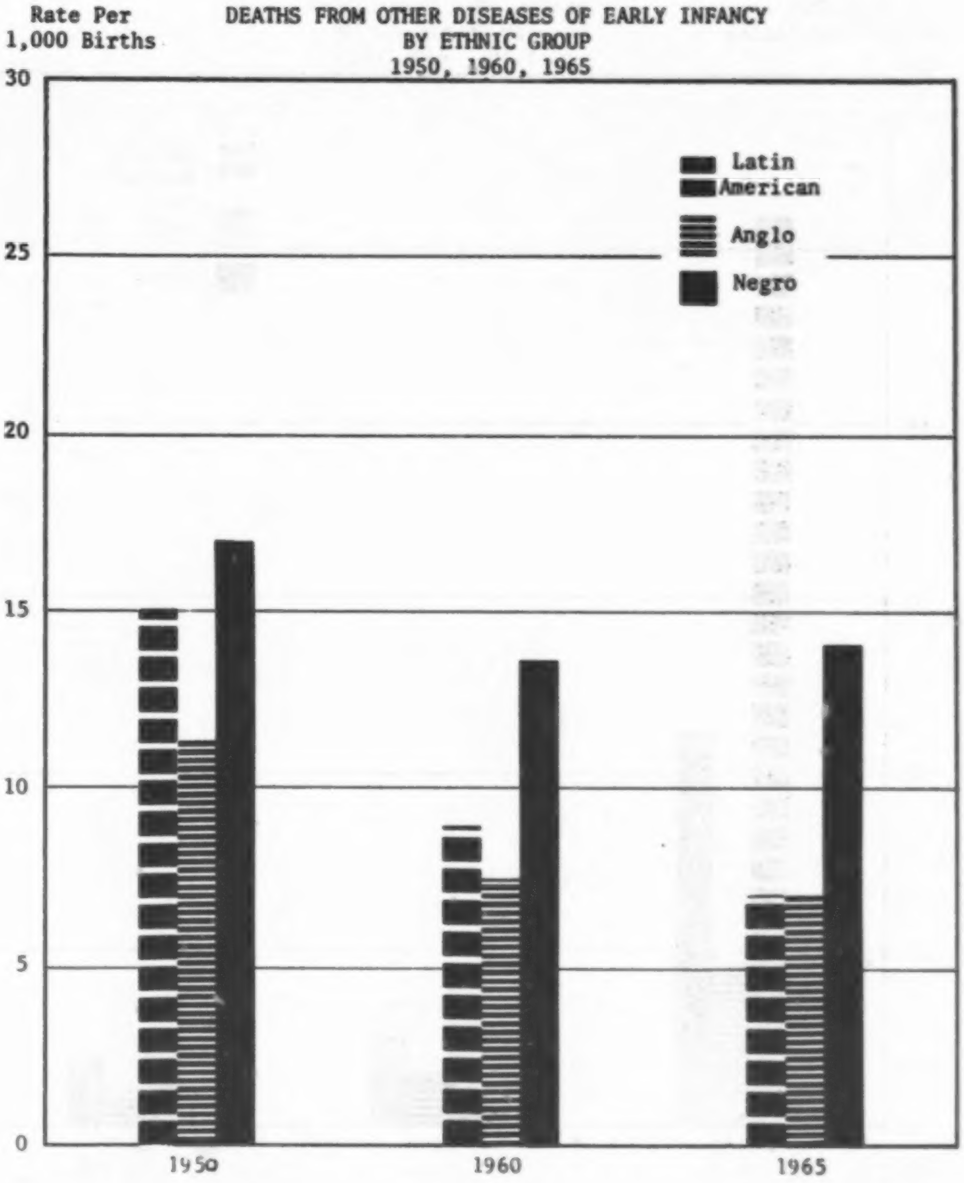


FIGURE 16

DEATHS FROM TUBERCULOSIS
BY ETHNIC GROUP
1950, 1960, 1965

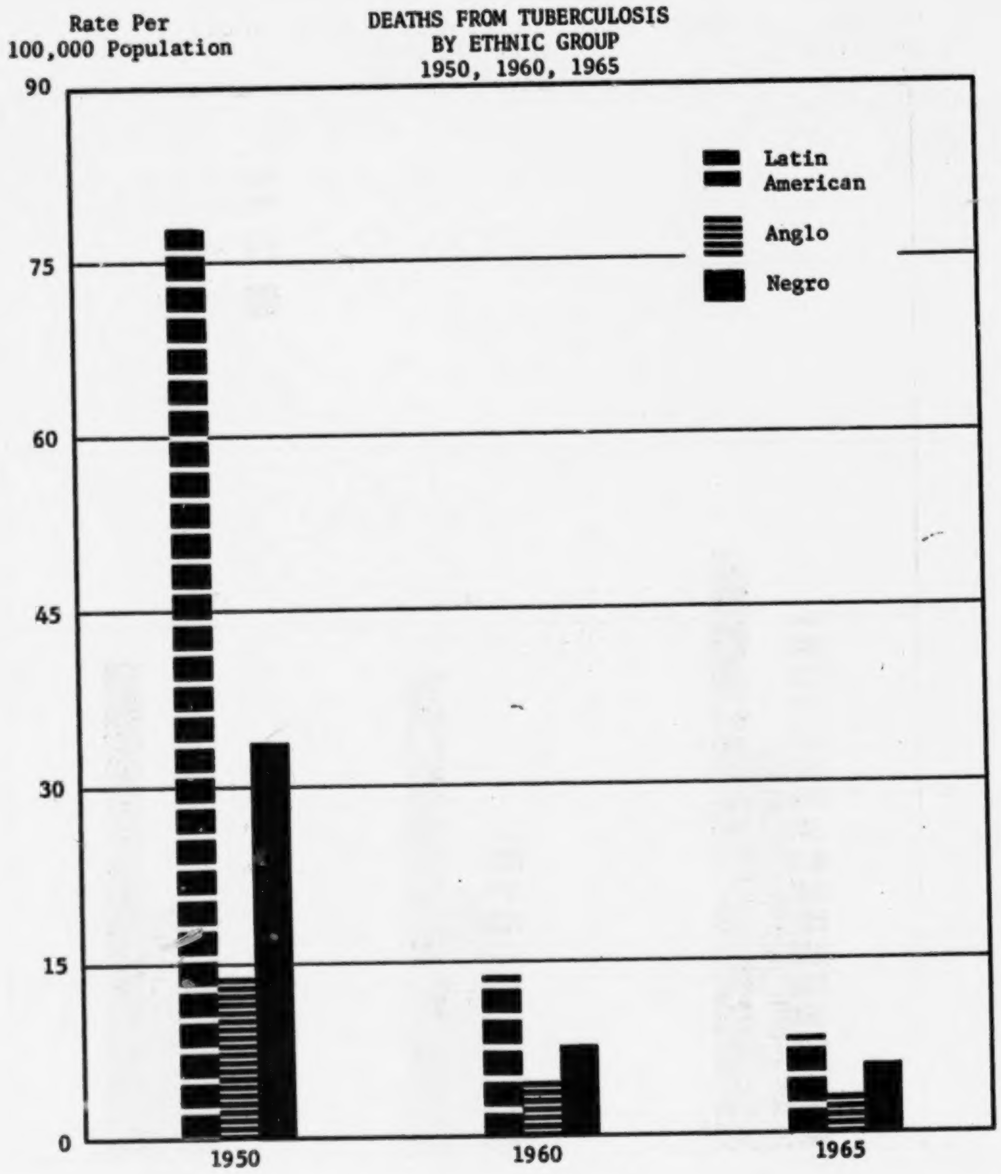


FIGURE 17

DEATHS FROM DYSENTERY
BY ETHNIC GROUP
1950, 1960, 1965

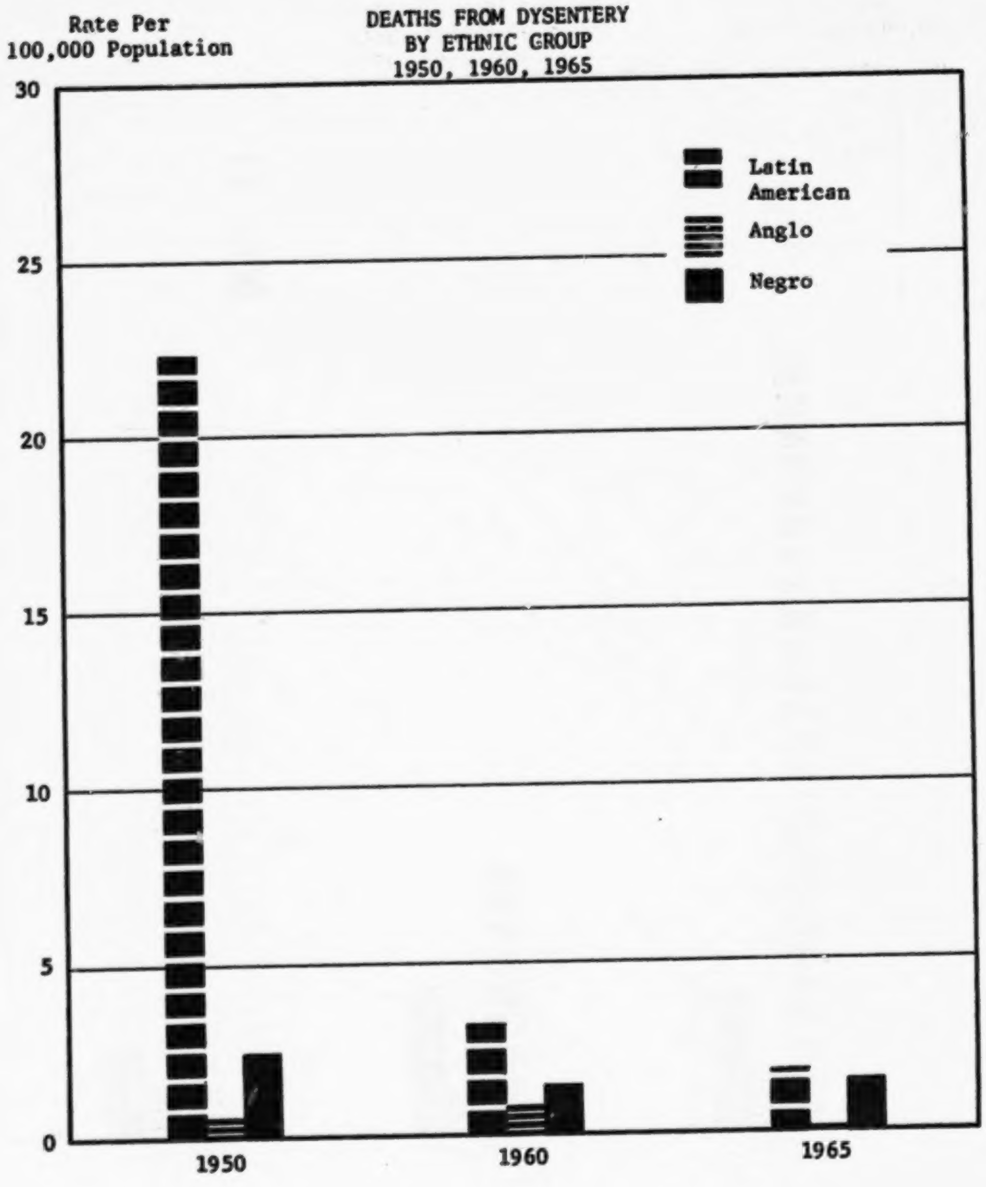


FIGURE 18

DEATHS FROM GASTROENTERITIS
BY ETHNIC GROUP
1950, 1960, 1965

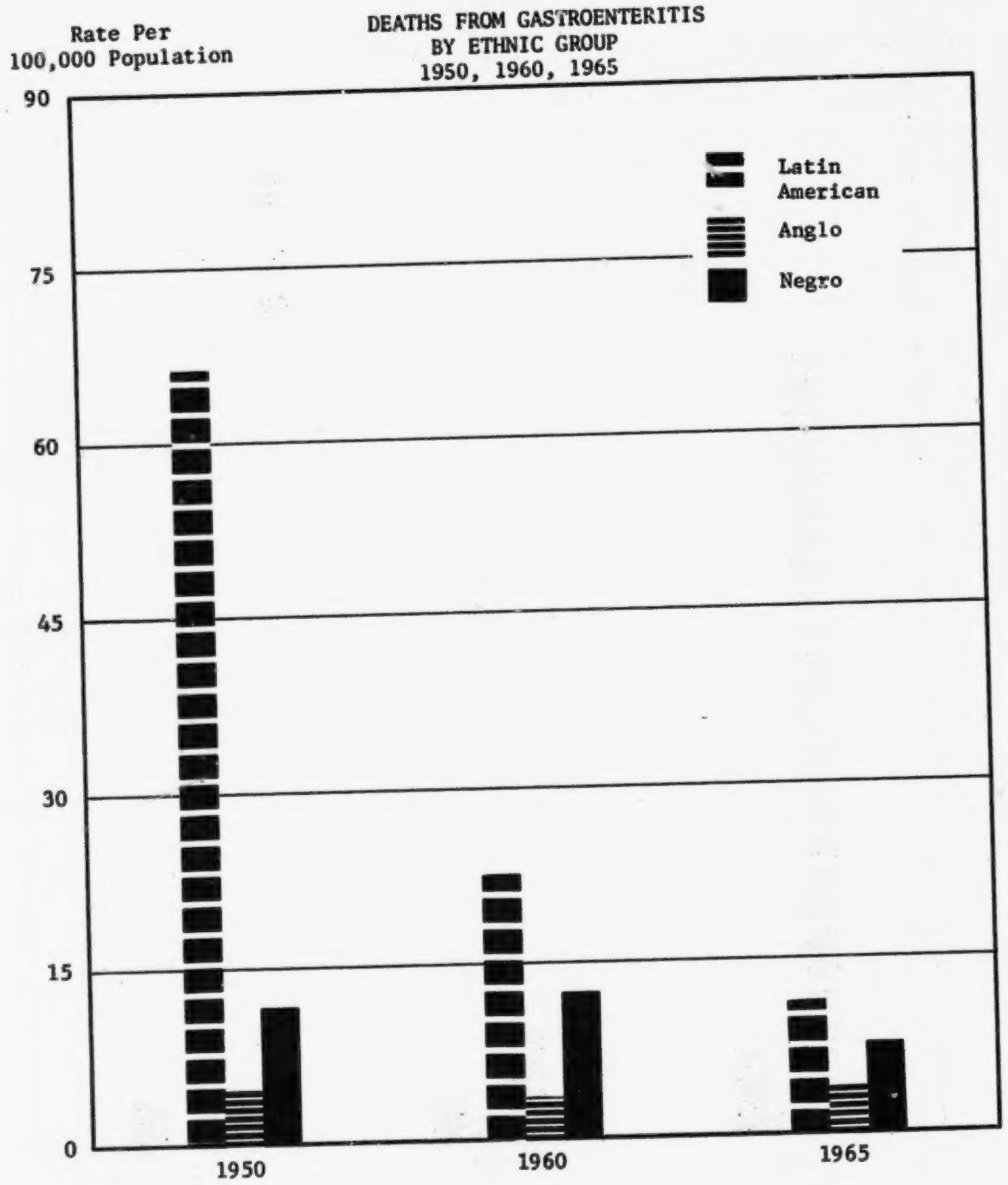


FIGURE 19

DEATHS FROM CONGENITAL MALFORMATIONS
BY ETHNIC GROUP
1950, 1960, 1965

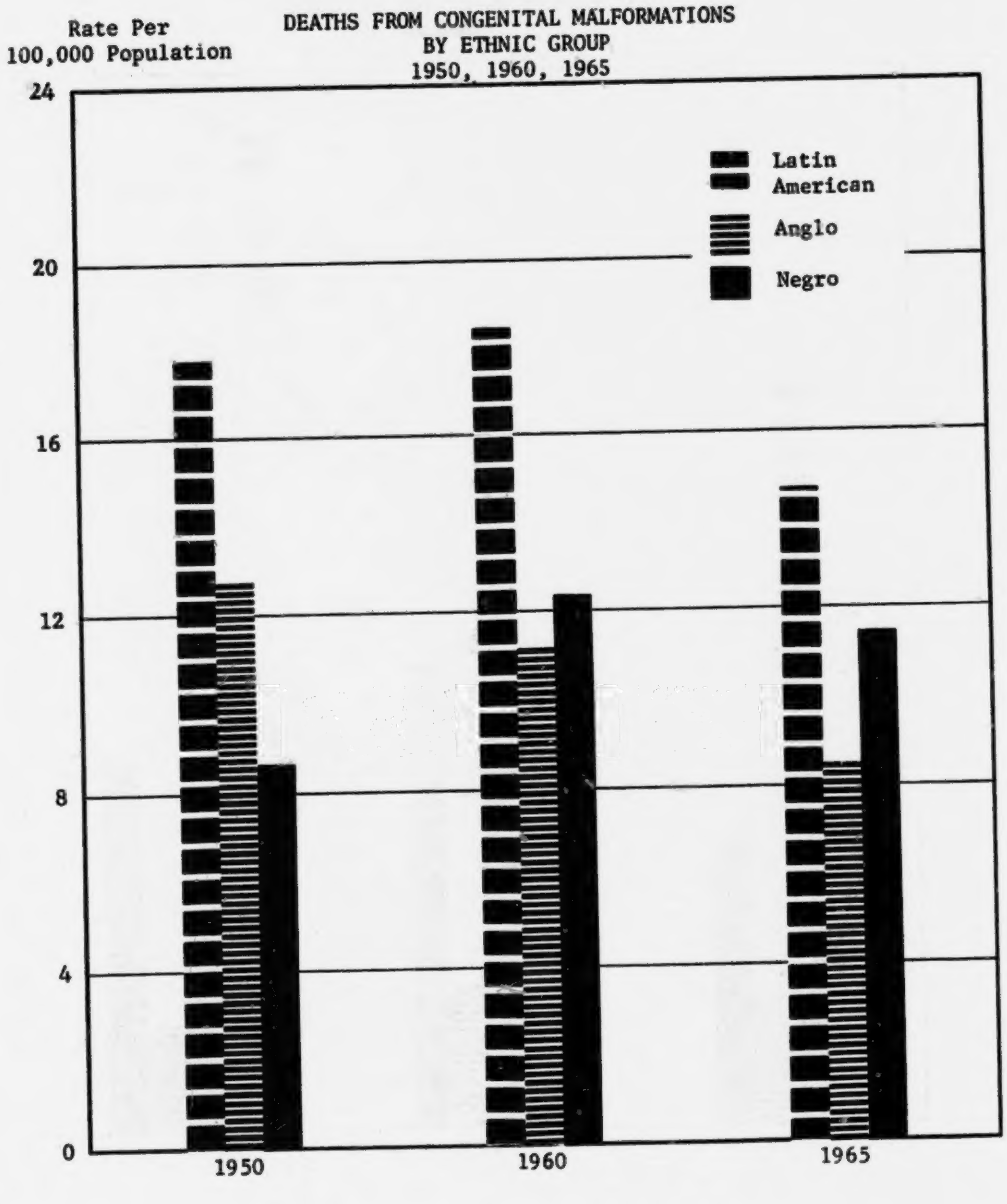
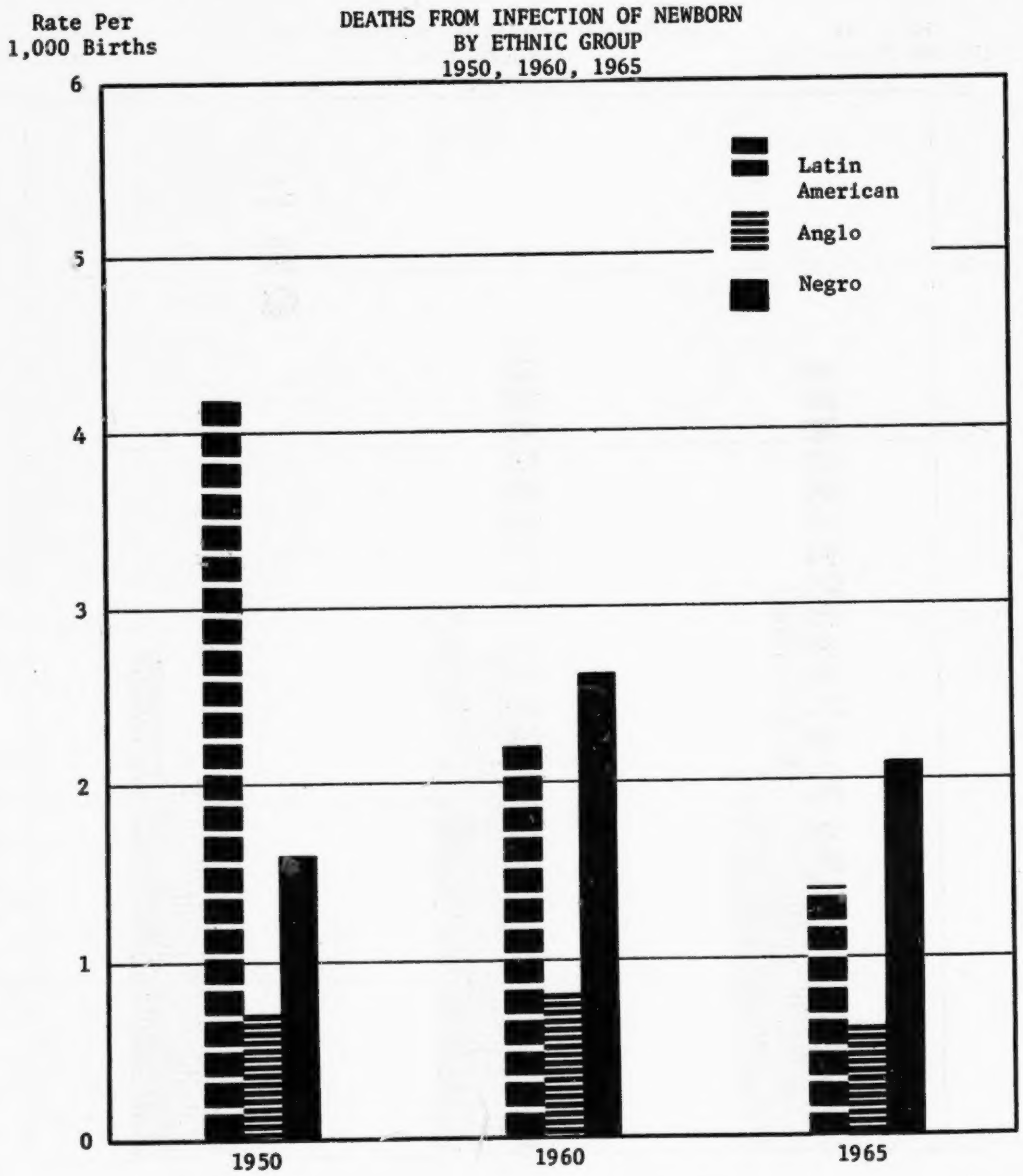


FIGURE 20

DEATHS FROM INFECTION OF NEWBORN
BY ETHNIC GROUP
1950, 1960, 1965



All of the preceding data has illustrated the very poor health conditions from which the Latin-American and Negro people of Texas suffer. It should be pointed out that health department figures are usually reported only for "White" and "Non-white." Only through much careful work and cooperation have the figures for the "White" group been delineated for the Latin-American and Anglo populations.

In order to further substantiate the conclusions suggested by these figures, health data from the three clusters of counties described in Chapter II is analyzed in the following paragraphs.

Vital Statistics

Table 9 contains selected vital statistics in the three groups of counties for the year 1964 under the heading of northern, southwestern, and eastern counties which respectively represent predominantly Anglo, Latin American, and Negro ethnic concentration of population. Table 9 contains information regarding fetal, infant, and neonatal deaths; deaths from congenital malformations; maternal deaths; and deaths from dysentery, gastroenteritis, and influenza-pneumonia. It also contains information relative to live births, physician and hospital deliveries, prenatal care, and live births with congenital malformations.

Careful study of health records for each of the counties presents interesting information with regard to deaths and live births in the three ethnic groups. Recorded birth injuries are significantly higher in the Latin-American counties with a rate of 21.4; the rate for the Anglo counties is 9.2; and for the Negro counties, 5.6. It is also interesting to note the higher rate of birth injuries in the Anglo counties over the Negro counties. The maternal death rate was considerably higher in the Latin-American counties, as were the rates for congenital malformations and infant deaths.

Records show that physicians delivered 99.8% of all babies in the Anglo counties, 63.0% in the Latin-American counties, and 79.8% in the Negro counties. In the Anglo counties, 99.7% of all live births were hospital deliveries; only 60.9% of the Latin-American and 78.7% of the Negro counties' live births were in hospitals. It is startling to note that while in the northern, or predominantly Anglo, counties the proportion of expectant mothers who had had no prenatal care was 1.4%, the corresponding figure for the southwestern or Latin-American counties was 7.8%, and for the eastern or Negro counties, 7.4%.

There was little difference among the counties in the rate of congenital malformations of live births. This may be due to the fact that congenital malformations are reported by the person delivering the infant, and midwives may not record congenital malformations as accurately as physicians or hospitals.

The data presented in Table 9 for the three selected groups of counties is very similar to the data obtained on the entire Anglo, Negro, and Spanish-surname population of Texas, reported in the first part of this chapter, and confirms the wide differences in death rates, birth injuries, and infant illnesses among the three ethnic groups. Certainly this indicates the need for

TABLE 9

SELECTED VITAL STATISTICS
IN CERTAIN CLUSTERS OF TEXAS COUNTIES
1964

	NORTHERN COUNTIES		EASTERN COUNTIES		SOUTHWESTERN COUNTIES		TEXAS	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
DEATHS	3,932	1,004.9	2,878	1,143.0	3,450	684.6	82,543	793.9
Fetal deaths*	127	18.3	70	17.6	276	18.1	3,610	15.5
Infant deaths*	143	20.7	119	30.0	501	32.8	6,303	27.2
Neonatal deaths*	105	15.2	72	18.2	344	22.3	4,316	18.6
Birth injuries, etc.**	36	9.2	14	5.6	108	21.4	1,500	14.4
Infection of newborn**	16	4.1	8	3.2	37	7.3	307	3.0
Diarrhea of newborn**	0	-	1	0.4	3	0.6	34	0.3
Other early infancy diseases**	45	11.5	28	11.1	95	18.8	1,859	17.9
Congenital malformations**	33	8.4	16	6.3	67	13.3	1,094	10.5
Maternal deaths**	2	0.5	0	-	9	1.8	89	0.8
Dysentery**	1	0.2	2	0.8	16	3.2	59	0.6
Gastroenteritis**	21	5.3	21	8.3	72	14.3	611	5.9
Influenza-pneumonia**	153	39.1	82	32.6	199	39.5	2,931	28.2
LIVE BIRTHS ***	6,912	17.7	3,962	15.7	15,286	30.3	233,773	22.2
Physician deliveries	6,903	99.8%	3,160	79.8%	9,630	63.0%	223,720	95.7%
Hospital deliveries	6,894	99.7%	3,120	78.7%	9,300	60.9%	222,288	95.1%
No prenatal care	100	1.4%	293	7.4%	1,197	7.8%	16,934	7.2%
With congenital malformations	56	0.8%	36	0.9%	105	0.7%	2,030	0.9%
POPULATION	391,299		251,606		503,903		10,397,000	

*Rate per 1,000 live births
**Rate per 100,000 population
***Rate per 1,000 population

further study into the adequacy of medical care provided the Negro and Latin-American populations of Texas.

CHAPTER VI

EDUCATION, ILLITERACY, AND MENTAL RETARDATION

Education is one key factor in the study of the problem of mental retardation within the context of the ethnic minority groups of Texas. Statistics show that there are considerable differences in the educational attainment in the three subgroups, and the implications of these differences are important for a study of mental retardation.

Browning and McLemore have pointed out that of the three major ethnic groups in Texas, the Latin-American population has consistently had the poorest education. In a study of all males, age 14 to 24, Clapp found that only 33.3% of the Latin Americans were enrolled in school, while the comparative rate for the Negro group was 34.9%. Corroborating these data are figures from the groups of ethnic project counties previously described, and indicated in Table 10. In the Anglo counties, the average number of school years completed was 10.2, which is very close to the Texas statewide median of 10.4. In the Latin-American counties, however, the average number of school years completed was only 5.8; in the Negro counties, the average was 8.4 school years completed. From these and other data it can be seen that the Latin-American population ranks consistently lowest on any measure of educational attainment (Browning and McLemore, 1964; Clapp, 1964).

Table 11 indicates the number of school years completed by persons 25 years of age and over from the different ethnic groups of Texas. These figures again indicate the fact that the Latin-American population of Texas is grossly undereducated in relation not only to the Anglo group but to the Negro group as well.

In commenting about these differences, Browning and McLemore propose a hypothesis that just as the economic level of minority ethnic groups declines with their concentration in the population, so does the educational level. They state, "The educational level of minority groups is inversely related to their proportional population concentration." Browning and McLemore further point out that while the Latin-American population is slowly moving in the direction of educational equality, a comparison of children in Texas age 16 to 19 reveals that the gap between the ethnic groups has widened. Thus, the Latin-American youths are more likely than the Negro or Anglo to drop out of school before the age of 19, although they are rapidly moving toward equality at lower educational levels. (Browning and McLemore, 1964).

Illiteracy in the Three Ethnic Groups

The Texas State Board of Education, in a study of illiteracy in Texas, found in 1964 that about 11.0% of the population 14 years and older and 13.4% of the population 25 years and older were illiterate. The study indicated that there were 731,218 individuals 14 years and older with less than five years of schooling.

TABLE 10

SCHOOL YEARS COMPLETED IN THREE SELECTED GROUPS OF TEXAS COUNTIES

County	Total Population of Counties	Percent Ethnic Distribution (Mean)	School Years[1]
Northern (17) (Anglo)	376,730	95% Anglo	10.2
Southwestern (12) (Latin American)	502,735	73.8% Spanish Surname	5.8
Eastern (16) (Negro)	247,835	42% Negro	8.4

[1] Mean of County Median

TABLE 11

PERCENTAGE DISTRIBUTION OF PERSONS 25 YEARS OF AGE AND OVER, BY YEARS OF SCHOOL COMPLETED, TEXAS ETHNIC GROUPS, 1950 AND 1960

ETHNIC GROUP	None	ELEMENTARY (1-8)	HIGH SCHOOL (9-12)	COLLEGE (1-4+)	TOTAL (25+)		MEDIAN YEARS COMPLETED
					Percent	Number	
Anglo							
1950	1.2	38.1	43.2	17.5	100.0	3,206,650	10.0
1960	1.1	31.2	45.5	21.2	100.0	3,881,846	11.5
Non-white							
1950	5.9	66.3	22.2	5.6	100.0	505,755	7.0
1960	5.4	54.8	31.4	8.4	100.0	587,954	8.1
Spanish Surname							
1950	27.8	60.2	9.9	2.0	99.9	400,995	3.6
1960	22.9	56.8	16.1	4.2	100.0	560,759	6.1

Source: (1) Persons of Spanish Surname, 1950, Table 6. (2) Persons of Spanish Surname, 1960, Table 7. (3) General Social and Economic Characteristics, Texas, 1960, Table 47.

Table: Browning, Harly L. and McLemore, S. Dale. A Statistical Profile of the Spanish-Surname Population of Texas, The University of Texas, 1964.

For purposes of this study, the Texas Education Agency (TEA) defined the illiterate as one with no formal schooling but differentiated another group, the functionally illiterate, as persons "with less than five years of formal schooling who do not have the education skills necessary to function effectively in modern society."

Two of the four basic assumptions or hypotheses proposed by those who conducted this study are relevant to the problem of mental retardation within the ethnic groups of Texas. First, it was assumed that there was a significant relationship between membership in minority ethnic groups and illiteracy. Second, it was hypothesized that there was a positive relationship between low socioeconomic status and illiteracy. As might have been anticipated, the TEA study concluded that the proportion of illiteracy among Latin-American and Negro ethnic groups was substantially higher than among Anglos. Figure 21 illustrates those counties having an illiteracy rate of 20% or more, and it is interesting to note that most of these counties are located in the extreme southwest portion of the state and are practically identical with those counties described in the previous chapter as being representative of the Latin-American population. The literacy study further pointed out that although the rate of illiteracy is high among all Latin-American persons, it is particularly high among children of foreign-born parents--in other words, children whose parents were born in Mexico.

It is probable that the researchers included mentally retarded persons in their determination of educational level and illiteracy. Indeed, the very definition used in the TEA study for both illiteracy and functional illiteracy would include most of the mentally retarded, both identified and unidentified, in all three ethnic groups. Certainly, mental retardation may be hidden in the figures of illiteracy, and, conversely, illiteracy may be masquerading as apparent mental retardation. It is important to attempt to make a distinction between these two problems, however, since one may be corrected and the other ameliorated. Not until better methods for separating these two problems, as the problems of mental retardation and mental illness are now separated, are developed can it be expected that much will be done to help the large number of Texans who are affected by one or the other or both of these problems

Table 12 indicates the number of individuals 14 years and over with less than five years schooling for the year 1960.

Special Education

It is interesting to compare ethnic group differences in the number of children placed in public school special education classes for the mentally retarded. In the groups of ethnic project counties previously described, the percent of total county enrollment in special education classes was .41% for the Anglo counties, .48% for the Negro counties, and .79% for the Latin-American counties. Attention is immediately drawn to the fact that special class placement is almost twice as high for the Latin-American group, and it is necessary to look more closely at some of the possible reasons for this.

TABLE 12

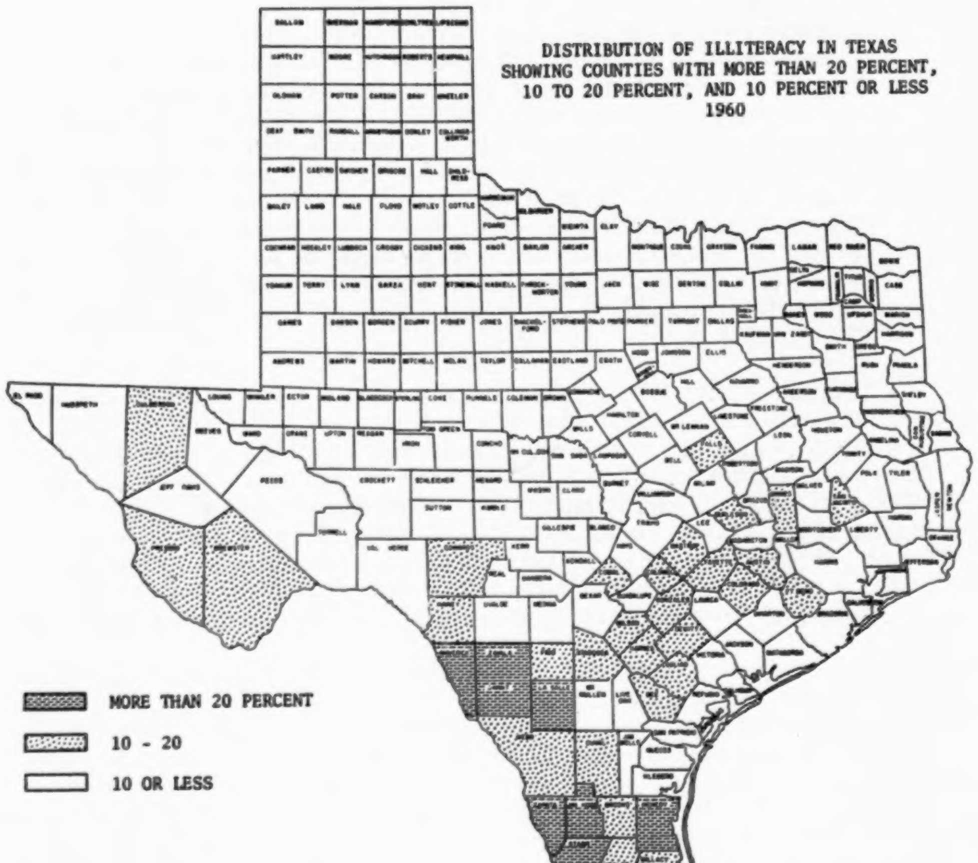
NUMBER OF INDIVIDUALS 14 YEARS AND OVER 64, WITH FIVE YEARS OF SCHOOLING OR LESS, FOR THREE TEXAS ETHNIC GROUPS BY RESIDENCE AND SEX 1960*

	AGE GROUPING					
	14-24	25-34	35-44	45-64	Over 64	Total
NON-WHITE						
RURAL						
Male	1,945	2,330	3,493	11,763	9,982	29,513
Female	1,200	1,341	2,043	7,290	7,898	19,772
URBAN						
Male	2,335	4,792	7,866	23,871	15,188	54,052
Female	1,734	2,877	5,955	17,816	14,254	42,636
Totals	7,214	11,340	19,357	60,740	47,322	145,973
LATIN						
RURAL						
Male	6,648	11,173	10,380	15,697	4,890	48,788
Female	6,108	9,243	8,749	11,835	3,803	39,738
URBAN						
Male	10,501	20,092	22,279	41,042	15,790	109,704
Female	12,300	25,303	27,531	44,626	17,402	127,162
Totals	35,557	65,811	68,939	113,200	41,885	325,392
ANGLO						
RURAL						
Male	3,586	4,398	7,108	24,946	25,241	65,279
Female	2,497	2,462	4,113	14,734	18,946	42,752
URBAN						
Male	5,455	7,121	11,050	30,813	28,906	83,345
Female	4,683	5,159	7,565	23,082	27,988	68,477
Totals	16,221	19,140	29,836	93,575	101,081	259,853
TOTAL	58,992	96,291	118,132	267,515	190,288	731,218

*Abstracted from 1960 Census Reports

Source: Study of Illiteracy as Related to Vocational Education
Texas Education Agency, 1964.

FIGURE 21



DISTRIBUTION OF ILLITERACY IN TEXAS
SHOWING COUNTIES WITH MORE THAN 20 PERCENT,
10 TO 20 PERCENT, AND 10 PERCENT OR LESS
1960

There is evidence to suggest that intelligence tests do not represent a true measure of the scholastic experience or ability of these two major ethnic groups. The following discussion of this question points out some of the current thinking in this area.

> Until recently, differences in children's I. Q. were attributed largely to native endowment; very little of the variation was attributed to the effects of environment. The more recent research has demonstrated that for children growing up under adverse circumstances, the I. Q. may be depressed by a significant amount and that intervention at certain points (and especially in the period from ages three to nine) can raise the I. Q. by as much as ten to fifteen points. Such effects have been most clearly demonstrated for children with initial I. Q. 's of less than 110. While there is nothing sacred about the I. Q., it has been a useful indicator of general learning capability in the schools. A change in I. Q. is symptomatic of a change in general learning capability, and this is likely to be verified by more direct measures of school learning. Furthermore, the measurement of the culturally deprived child's intelligence at one point does not determine the upper limits of what he might be able to learn in the schools if more favorable conditions are subsequently provided in the home and/or in the school (Bloom, Davis, Hess; 1965, p. 12).

There is a surfeit of reports in the literature describing the low school achievement of most Latin-American children "proving" that the majority of them are culturally disadvantaged, further handicapped by language and communication problems and alienated toward education (Gonzales, 1932, Hernandez, 1938; Ratliff, 1960). Other investigators have challenged these results, pointing out that all tests of intelligence are inherently biased against any child whose native language is not English and/or any child whose cultural frame of reference is not that of the standard Anglo middle class (Corwin, 1961; Garth, et al, 1936; Rice, 1964).

The conclusion from all this information seems to be that none of the standard measures of intelligence is appropriate for any child, including the Latin American, who is not fully integrated into Anglo middle-class culture. Jensen compared high I. Q. Anglo and Latin-American children with low I. Q. Anglo and Latin-American children on a created test of learning ability. He found that the Anglos of low I. Q. were slower learners on this new test than the Latin-American children of the same low I. Q.; there was no difference between the Anglo and Latin-American children of the high I. Q. group. Jensen flatly states that the majority of Latin-American children demonstrating low I. Q. on the California Test of Mental Maturity are probably actually quite normal in learning ability (Jensen, 1961). Sanchez had previously demonstrated this point. He tested a second-grade group of bilingual children and found that the median I. Q. was 72. Working on the assumption that the test reflected a function of the school, remedial instruction in language and language arts was given over a two-year period, with the result that the median I. Q. score was "raised" to approximately 100, or normal. The author commented, "If initial test results had been accepted at face value, a large percentage of the children would have been classified as belonging in special classes for the dull, and some even as belonging in institutions for the feebleminded." (Sanchez, 1934)

The important implication for all of this would appear to be that, too often, cultural and language factors present a handicap to the learning of Latin-American children in our school classes as they are now constituted. School, therefore, becomes a place of failure, and it is quite possible that special education may epitomize this failure to many Latin-American children and their parents. Another obvious implication is the possibility that many Latin-American children placed in special education may not have inherent limitations in their learning ability, but rather may be suffering from the handicap of inappropriate instruction.

CHAPTER VII

CHARACTERISTICS OF RESIDENTIAL SCHOOL ENROLLMENT

The State of Texas has attempted to meet the needs of the mentally retarded requiring residential care by building special schools. The Department of Mental Health and Mental Retardation administers six special schools which have a combined capacity of 11, 500 beds. Three additional schools for the mentally retarded are under construction or in the planning stage. These new schools will add approximately 2, 900 beds to the present capacity over the next three years. However, it is anticipated that the waiting list, if the present trend persists, will continue to expand and will remain lengthy despite the opening of the new schools.

Applications for admission to special schools continue to be received by the Texas Department of Mental Health and Mental Retardation at a rate of 1, 500-1, 800 annually. It is becoming increasingly apparent that a sizable portion of the applicants could and should be served locally or regionally if adequate resources are made available to the retardate and his family. Two comprehensive community mental retardation centers will soon be operated by the Department and several more are in the planning stages.

Private residential facilities serve a relatively small number of mentally retarded; nevertheless, they play an important role in the array of available institutional services. As contrasted with the large state-operated facilities, the private installations often have better staffing ratios, and they have some flexible program policies. Usually, however, the fees for private facilities are beyond the financial capabilities of most families of the mentally retarded, particularly those in the two groups being studied.

A study of the waiting lists for Texas' state schools was made by Vowell and others in 1962. Their conclusions indicated that many applicants for admission to the state schools could be cared for at home if adequate and appropriate resources were available (Vowell, Sloan, Weir, and Peck, 1962). A similar conclusion was reached by the President's Panel on Mental Retardation for the nation as a whole, and the Texas Department of Mental Health and Mental Retardation, in additon to the construction of new schools, has begun the development over the state of community comprehensive mental retardation service centers. It is hoped that the development of such centers will reduce the need for institutionalization of many mentally retarded persons.

In order to determine the utilization of state schools by Texas ethnic groups, the Negro, Latin-American, and Anglo populations now served by the state schools were studied. Data was gathered relative to the characteristics of 3, 561 state school residents within the three major ethnic groups who were admitted during the two-year period 1964-1965. It was found upon examination of coded IBM cards supplied by the Department that this was the group with the most complete data available in all areas.

Table 13 indicates the number and proportion of admissions for the years 1964 and 1965 both by sex and ethnic group. In each of the ethnic groups there was a predominance of males over females, running at approximately 60% males and 40% females.

Table 14 shows the distribution of state school residents by institution, ethnic group, and sex as of August 31, 1965. At that time the total resident population was approximately 11,000.

Figure 22 presents some rather interesting information relative to the age of admission into the state schools by ethnic group for three-year periods. All admissions beyond the age of 30 were lumped together, and it is interesting to note that the Anglo group had better than twice as many admissions past the age of 30 than did the Latin or Negro group. The highest proportion of admissions was between the ages of 6 and 17, as might be expected. The Latin-American and Negro group had a high percentage of admissions during the periods 6 to 8 and 9 to 11 years; the highest percent of admissions for the Anglo group was for age 30 and over. Figures 23, 24, and 25 indicate the number of students admitted by age for each of the three groups.

It might be expected that both the Negro and Latin-American groups would tend to have their children admitted to the state schools at a later age; however, this was found to be a false assumption. The mean age for the Anglo residents admitted during this two-year period was 18.55 for 2,430 residents; Latin Americans, 14.22, for 593 residents; and Negroes 12.85, for 548 residents. Such factors as the resistance of Negro and Latin-American families to institutional placement, the lack of awareness of services available, migration of large groups within the Latin-American and Negro counties would be expected to have the effect of delaying institutionalization of children from these groups until a later age. The contrary being provided at the local level enabled Anglo children to remain in their homes longer, thus postponing institutional placement. There is a possibility also that there may be more Anglo children enrolled in private residential schools of various kinds in the early years, thus postponing the time of their admission to the state school and raising the mean age of this group.

As indicated in Table 15, the mean I. Q. of the three groups in Texas state schools ranged from 30.20 for Latin Americans to 31.63 for Negroes and 34.25 for Anglos. It was found that this information was not available in some cases, and these were excluded from the computations. An F test indicated that the differences were significant at less than the .01 level.

The following description was taken from reports of the Texas Department of Mental Health and Mental Retardation titled "Data for Planning, Report 1."

TABLE 13

CHARACTERISTICS BY ETHNICITY AND SEX
ADMISSIONS TO TEXAS STATE SCHOOLS FOR THE MENTALLY RETARDED
1964 and 1965

SEX	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
Male	1460	60.1	337	61.5	352	59.1
Female	970	39.9	211	38.5	244	40.9

TABLE 14

DISTRIBUTION OF STUDENTS RESIDENT* IN STATE SCHOOLS FOR THE MENTALLY RETARDED ON 8/31/65 BY INSTITUTION, ETHNICITY AND SEX

ETHNICITY AND SEX	AUSTIN	TRAVIS	MEXIA	ABILENE	DENTON	LUFKIN	TOTAL
Anglo male	532	1255	615	775	722	160	4059
Anglo female	705	-	1375	798	593	162	3633
Negro male	157	222	132	68	76	-	655
Negro female	93	-	273	50	46	-	462
Latin male	215	289	26	154	30	9	723
Latin female	314	-	89	149	43	2	597
Other male	1	3	1	1	-	-	6
Other female	2	-	1	2	1	-	6
Totals	2,019	1,769	2,512	1,997	1,511	333	10,141

*Resident Population

Source: Characteristics of Residents in State Schools for the Mentally Retarded, 1965. Texas Department of Mental Health and Mental Retardation 1966.

FIGURE 22

AGE AT ADMISSION BY ETHNIC GROUP
IN TEXAS STATE SCHOOLS FOR THE MENTALLY RETARDED
Two-Year Period 1964 and 1965

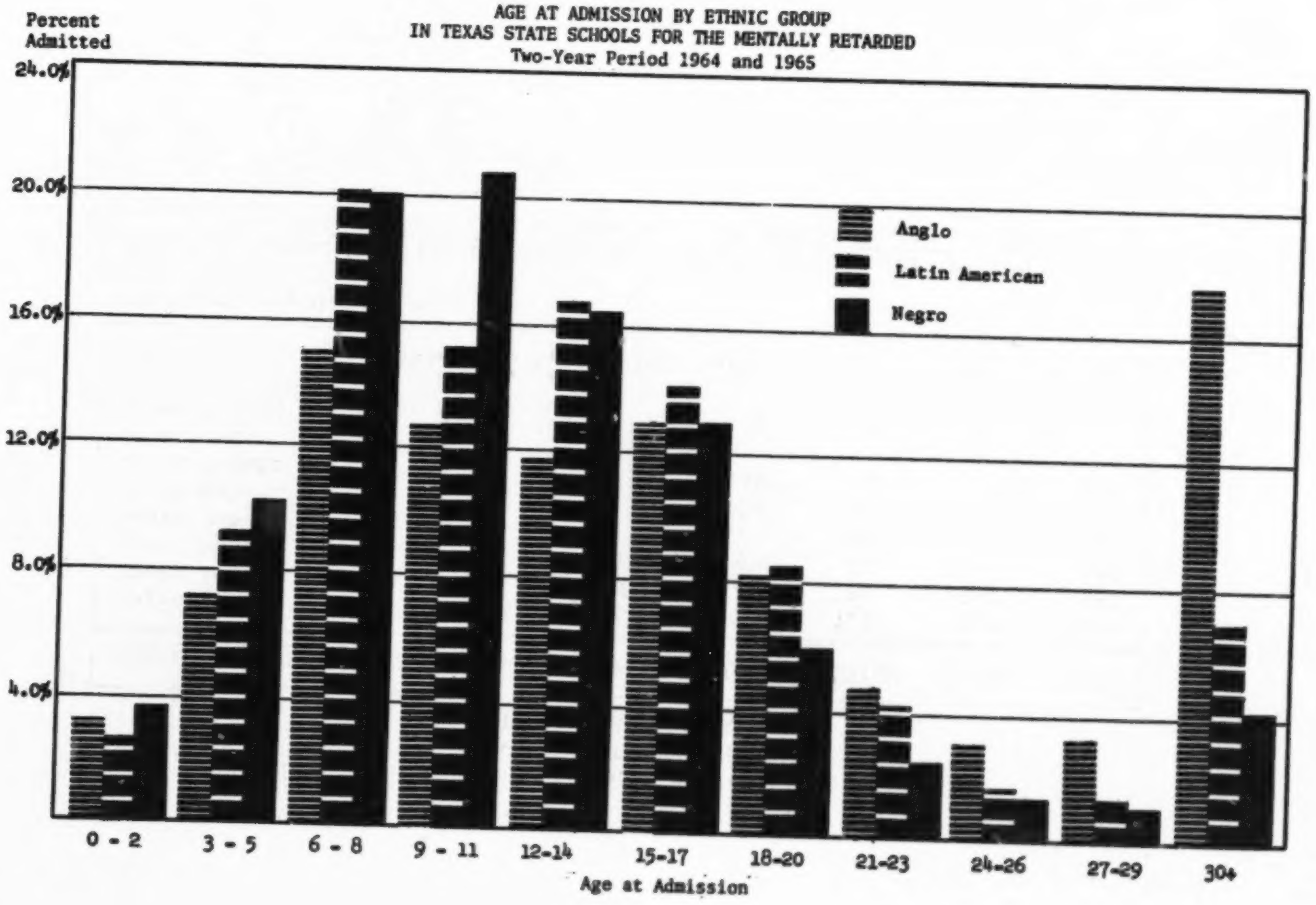


FIGURE 23

AGE AT ADMISSION TO TEXAS
STATE SCHOOLS FOR THE MENTALLY RETARDED
Two-Year Period 1964 and 1965

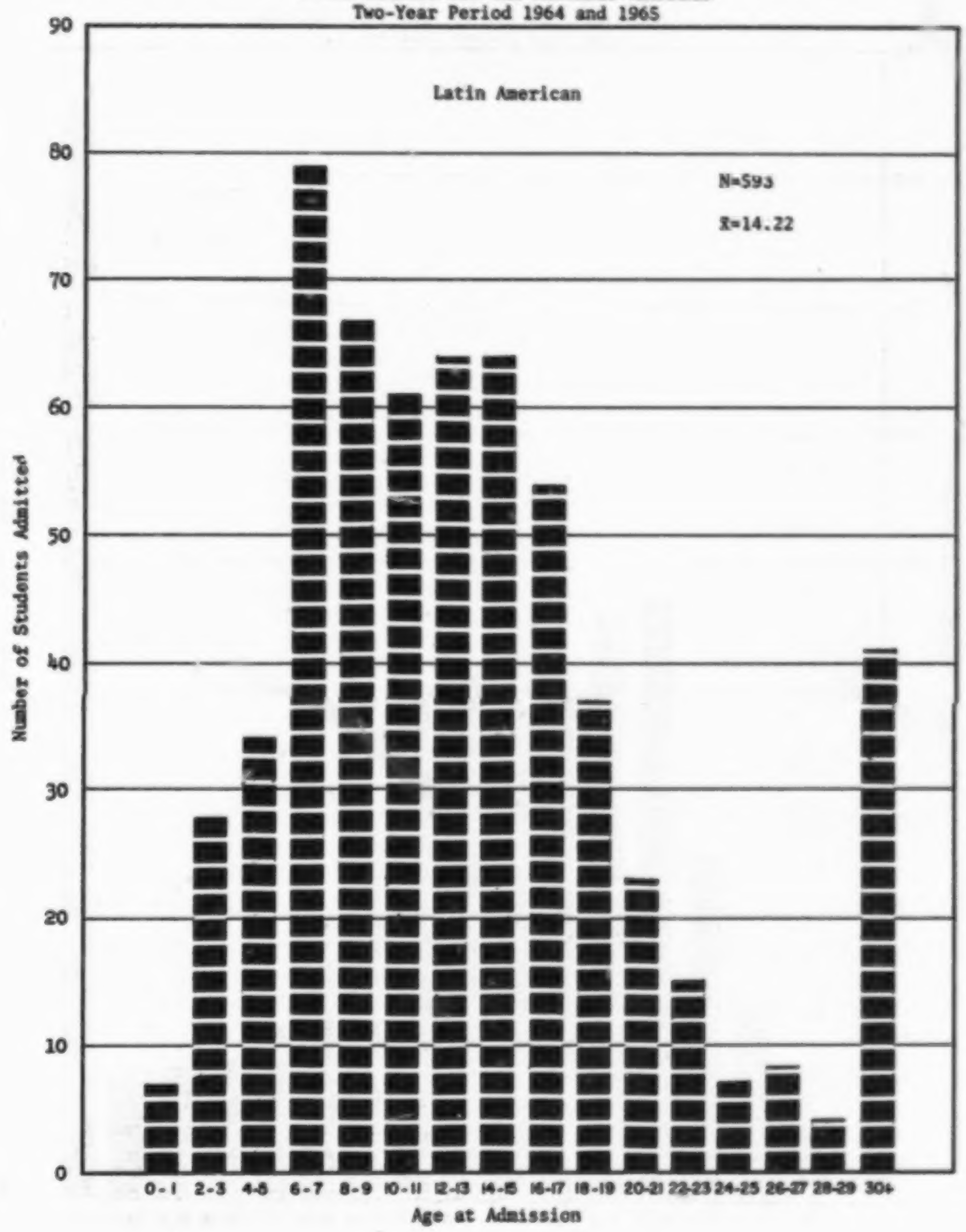


FIGURE 24

AGE AT ADMISSION TO TEXAS
STATE SCHOOLS FOR THE MENTALLY RETARDED
Two-Year Period 1964 and 1965

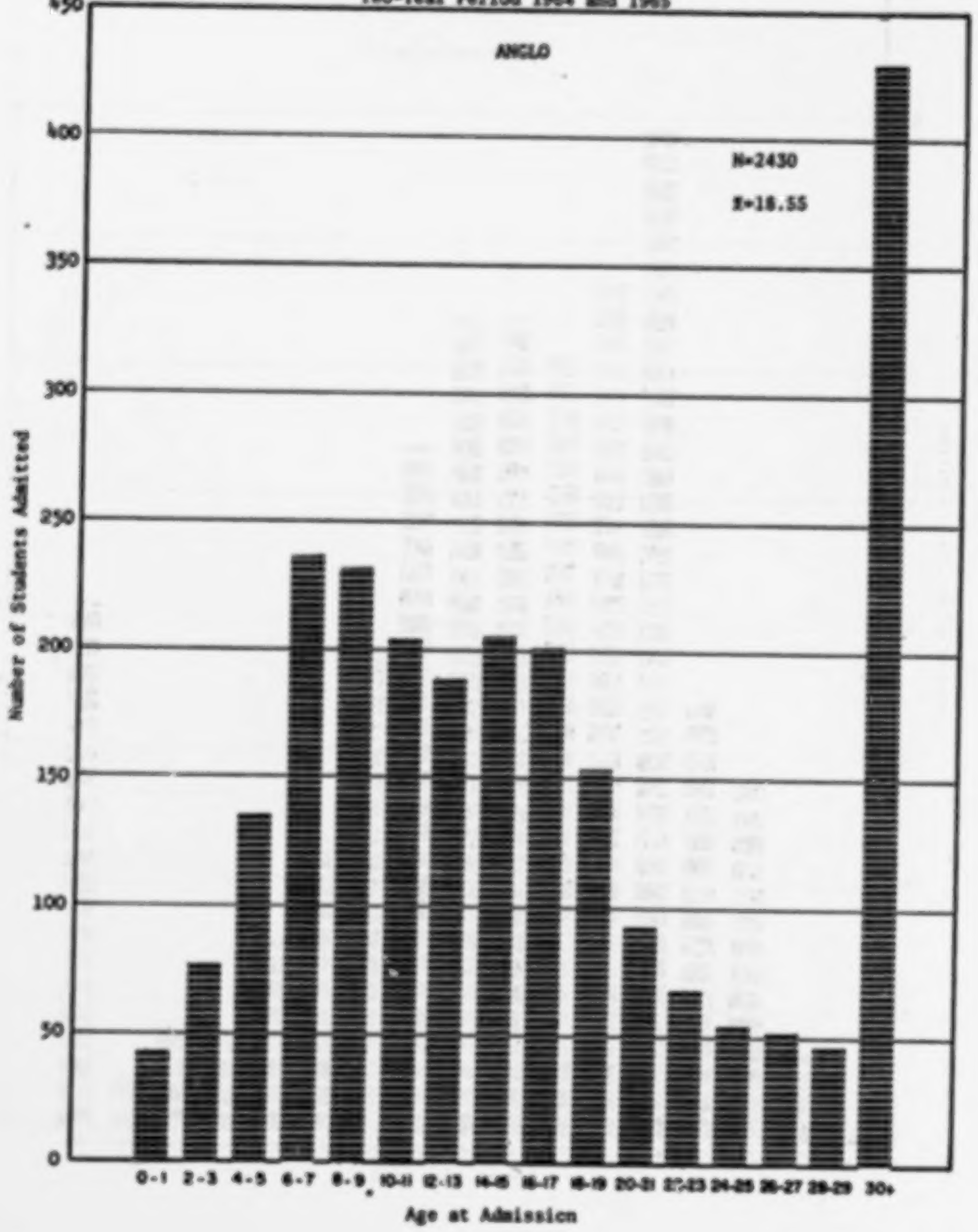
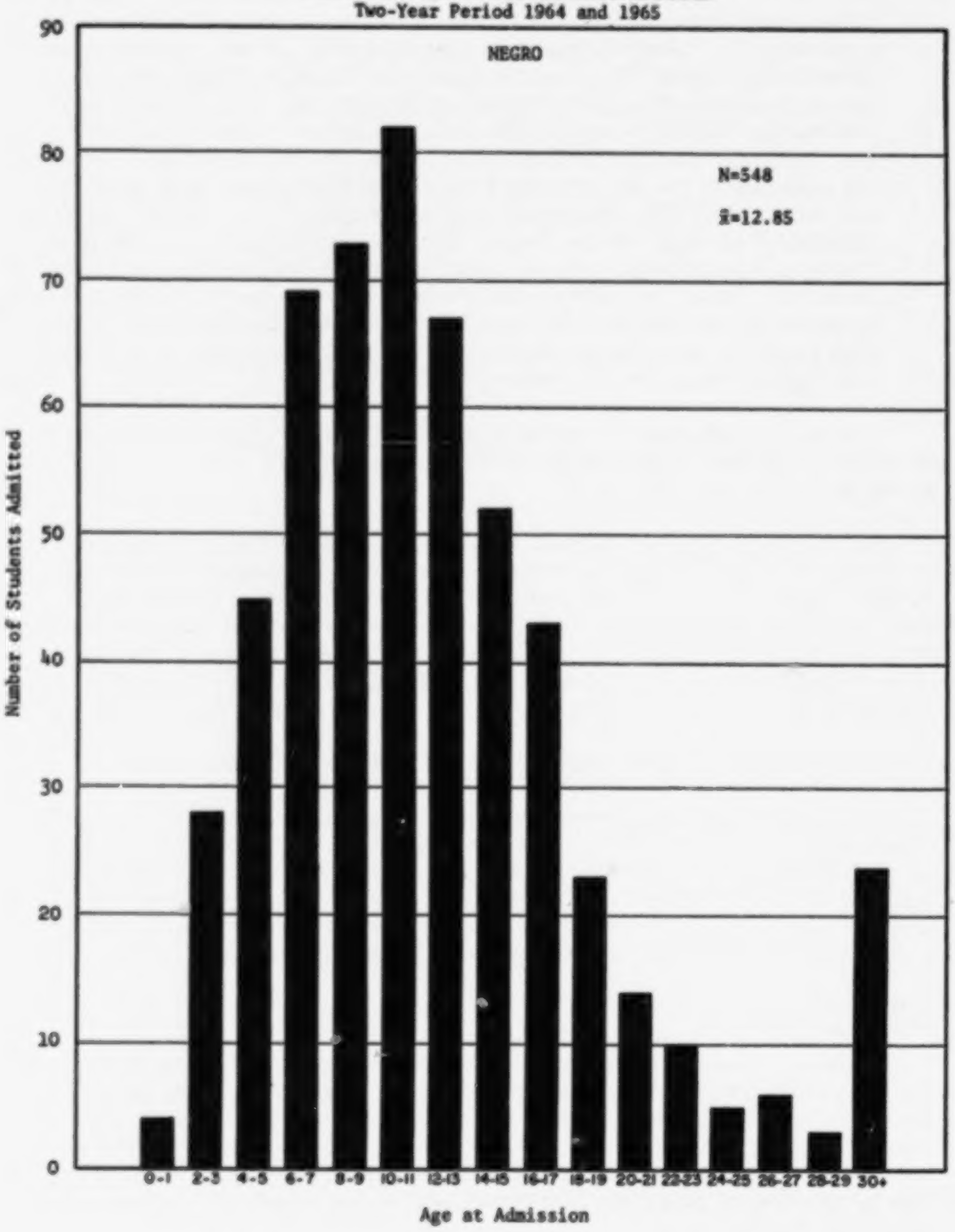


FIGURE 25

AGE AT ADMISSION TO TEXAS
STATE SCHOOLS FOR THE MENTALLY RETARDED
Two-Year Period 1964 and 1965



The report noted the following:

> There are some interesting variations on the basis of ethnicity which need intensive study. For example, when accumulated admissions for the past five years are plotted on the maps of the state, differential patterns become visible which are apparently associated with ethnicity. Anglo-American retarded persons admitted to state schools are drawn from most counties in Texas, although proportional representation is not apparent (Figure 26). The admissions pattern for Mexican-Americans shows counties in the High Plains and Panhandle regions with unusually high movement, while from the counties in the Rio Grande Valley with high proportions of Mexican-Americans the admissions are low (Figure 27). Almost the same fluctuation is apparent for Negro-Americans (Figure 28). The High Plains and Panhandle counties, with relatively few Negro-American residents, have sent many such persons to the schools for the mentally retarded during the past five years. The East Texas counties with high proportions of Negro-American residents have sent relatively few Negro-Americans to state schools.

Figure 29 indicates the above report's figures of the characteristics of retarded persons admitted to Texas state schools by sex and ethnic group for the years 1958-1965.

In the three clusters of counties previously described and illustrated in Figure 1, it was found that the rate per 1,000 population in the state schools as of August 31, 1965 was 1.48 for the northern or Anglo counties, 1.29 for the eastern or Negro counties, and 0.76 for the southwestern or Latin-American counties. Complete data on admissions to the state schools for the mentally retarded within the three clusters of counties is indicated in Tables 16, 17, and 18.

Institutional Status and Adaptive Behavior by Ethnic Group

Tables 19a and 19b point out the preponderance of admissions in the custodial group for all three ethnic groups. The Latin Americans had a slightly higher percent in the custodial category than did the Negroes or Anglos. The proportion in each category and in each ethnic group is relatively constant for both male and female. The adaptive behavior level for both male and female is indicated in Tables 20a and 20b.

Source of Referral

Relatives and the state board provided the major source of referrals for the Anglo group, while relatives, judges, lawyers or legal referrals, the state board, or social workers accounted for the majority of referrals in the Negro and Latin-American group. Proportions generally hold true for both male and female, as indicated in Tables 21a and 21b. The proportion of referrals by private physicians, clinics, ministers, etc., was very small.

TABLE 15

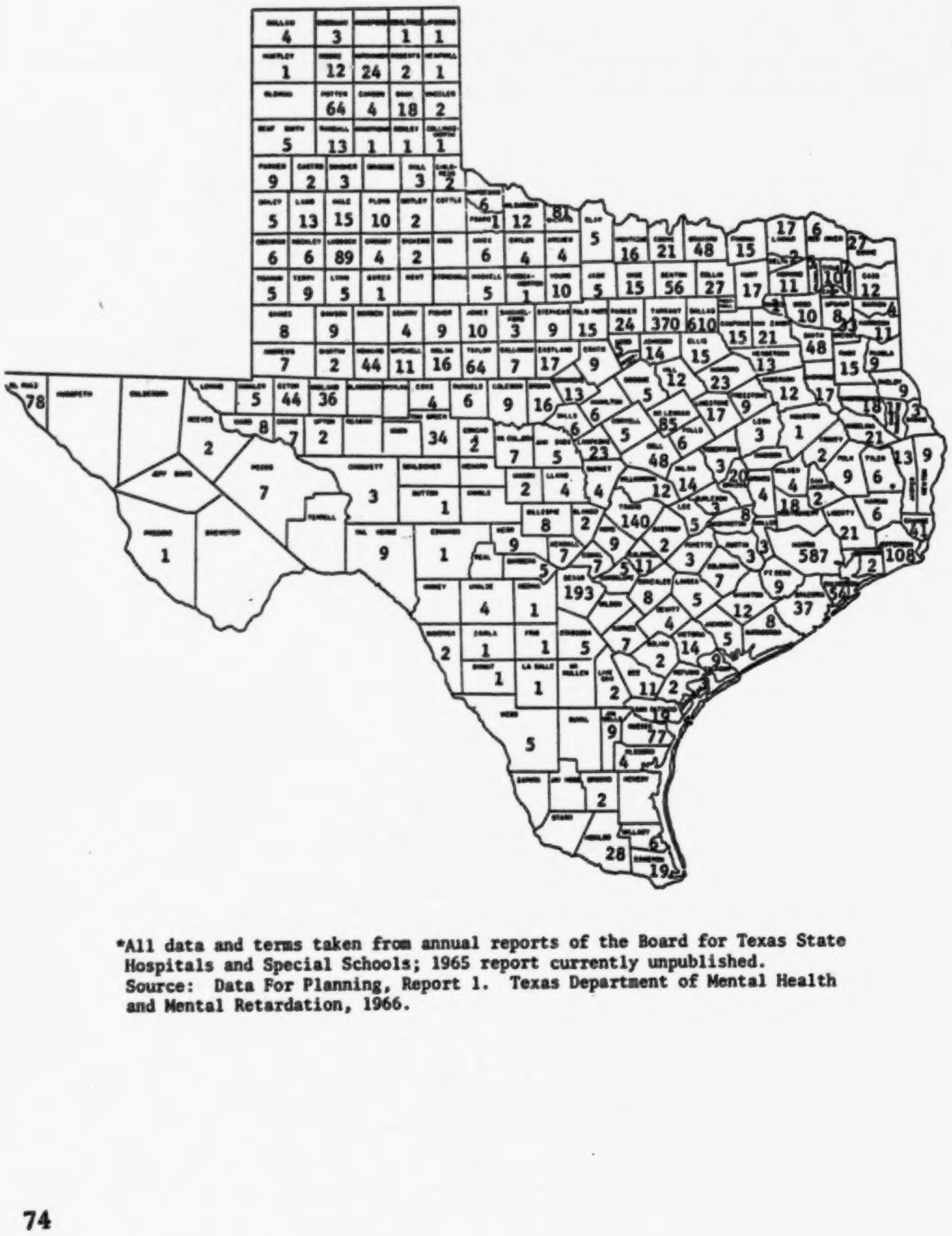
I.Q. OF TEXAS STATE SCHOOL RESIDENTS
BY ETHNIC GROUPS
1964 and 1965 Admissions

	$\bar{X}$	N	S.D.
Anglo	34.25	2053	19.91
Negro	31.63	457	18.94
Latin American	30.20	515	19.94
	$F_{2,3022} = 10.25$*		

*Significant at less than .01 level

FIGURE 26

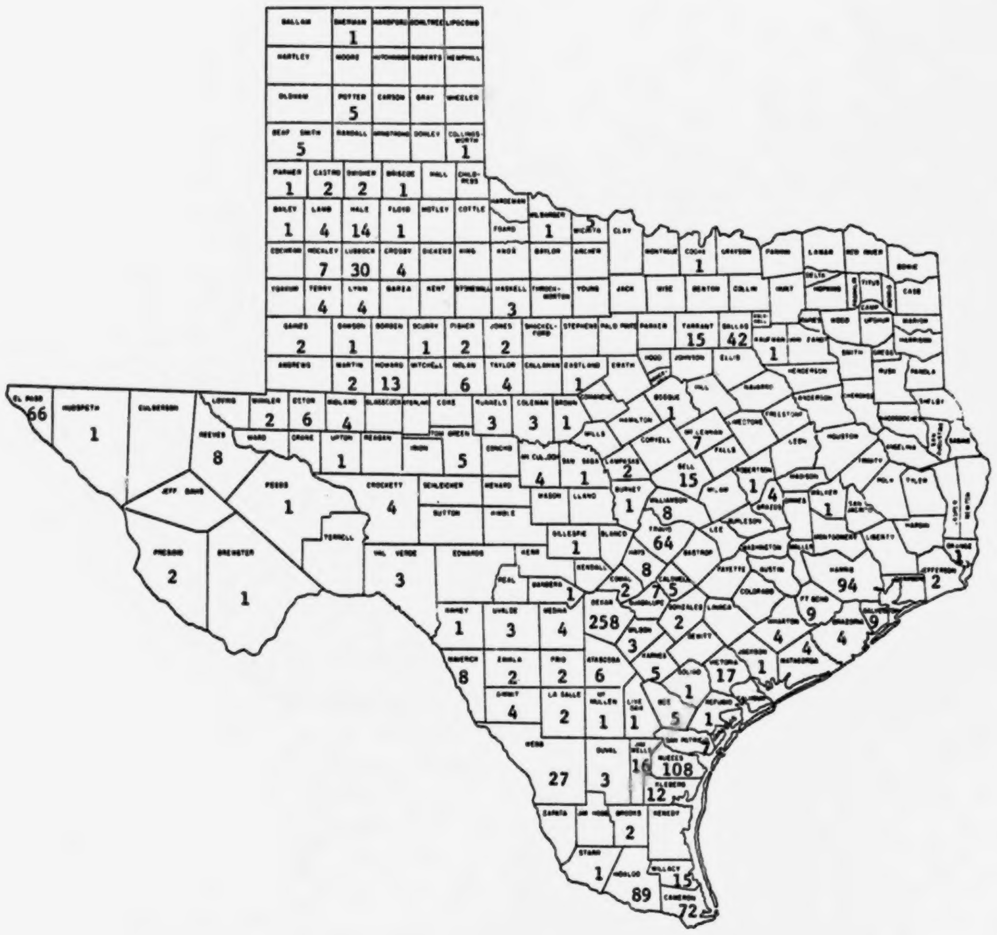
DISTRIBUTION OF ACCUMULATED ADMISSIONS* OF ANGLO-AMERICANS
TO TEXAS STATE SCHOOLS FOR THE RETARDED
BY COUNTY OF RESIDENCE, 1960-1965



*All data and terms taken from annual reports of the Board for Texas State Hospitals and Special Schools; 1965 report currently unpublished.
Source: Data For Planning, Report 1. Texas Department of Mental Health and Mental Retardation, 1966.

FIGURE 27

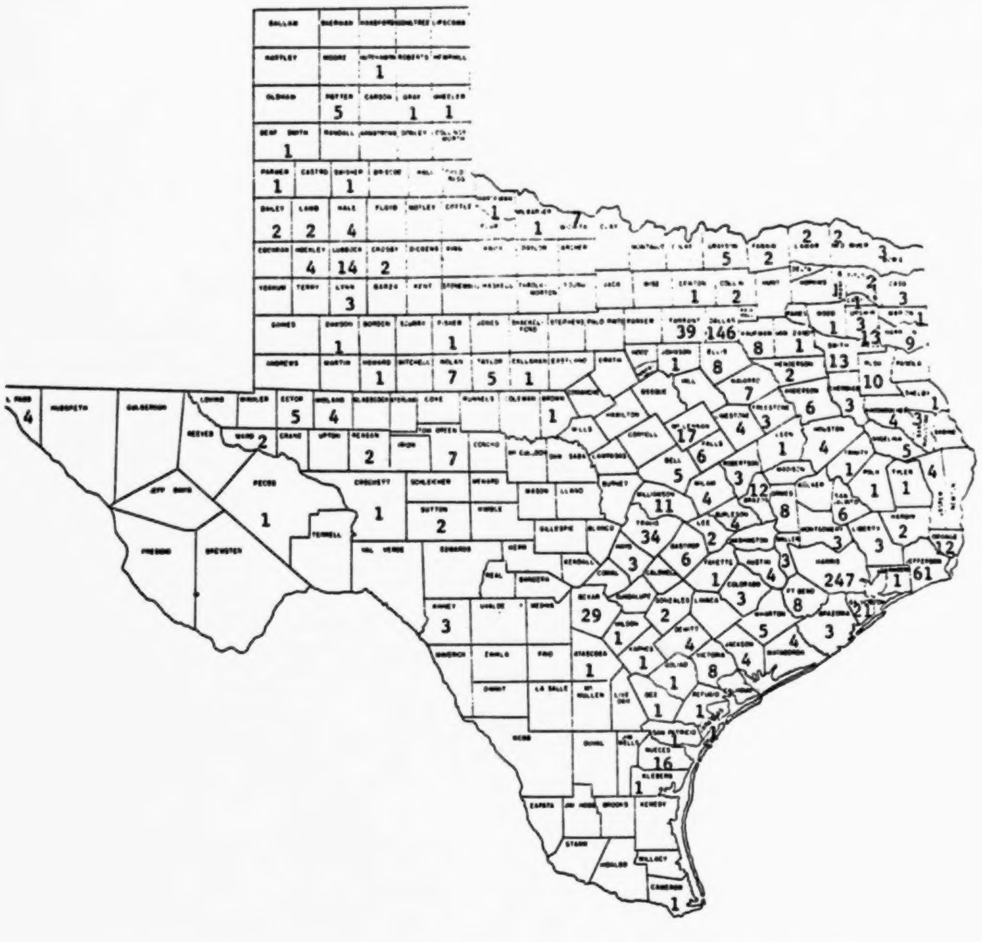
DISTRIBUTION OF ACCUMULATED ADMISSIONS* OF MEXICAN-AMERICANS TO TEXAS STATE SCHOOLS FOR THE RETARDED BY COUNTY OF RESIDENCE, 1960-1965



*All data and terms taken from annual reports of the Board for Texas State Hospitals and Special Schools; 1965 report currently unpublished.
Source: Data For Planning, Report 1. Texas Department of Mental Health and Mental Retardation, 1966.

FIGURE 28

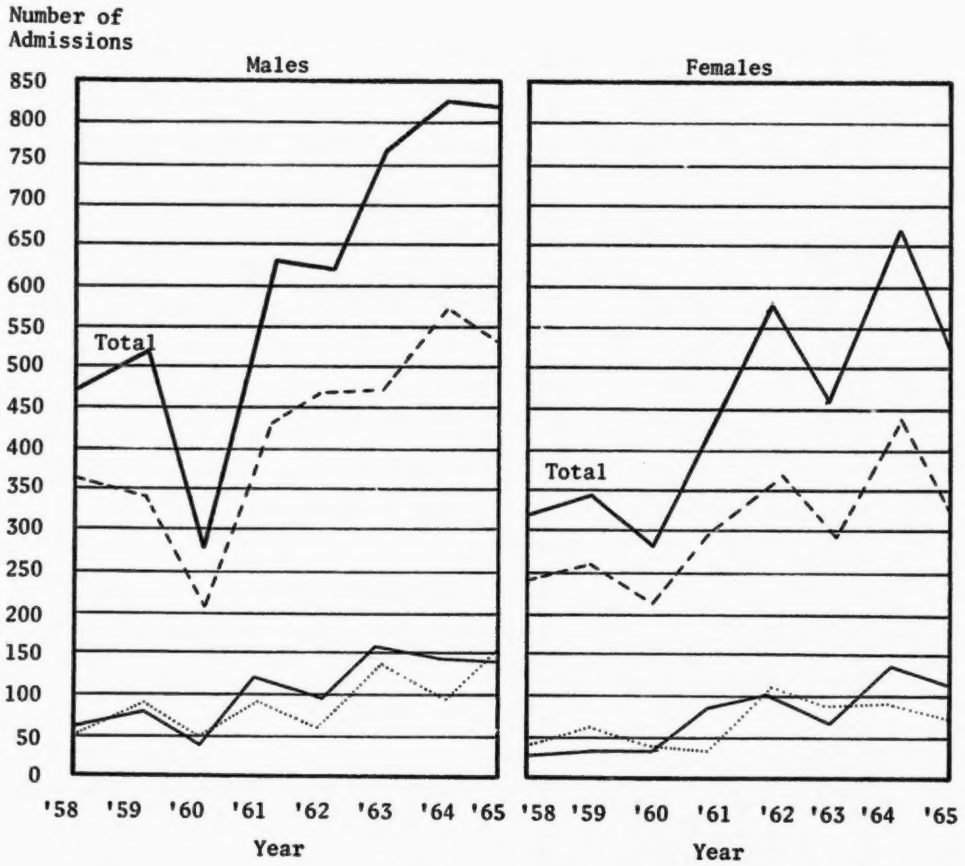
DISTRIBUTION OF ACCUMULATED ADMISSIONS* OF NEGROES
TO TEXAS STATE SCHOOLS FOR THE RETARDED
BY COUNTY OF RESIDENCE, 1960-1965



*All data and terms taken from annual reports of the Board for Texas State Hospitals and Special Schools; 1965 report currently unpublished.
Source: Data For Planning, Report 1. Texas Department of Mental Health and Mental Retardation, 1966.

Figure 29

CHARACTERISTICS OF RETARDATES ADMITTED TO TEXAS STATE SCHOOLS
BY SEX AND ETHNICITY, 1958*-1965**



--- = Anglo

—— = Latin

... = Non-white

*All data and terms taken from annual reports of the Board for Texas State Hospitals and Special Schools.

**Preliminary data from annual report for 1965 in preparation by Texas Department of Mental Health and Mental Retardation.

TABLE 16

SPECIAL EDUCATION AND STATE SCHOOL ENROLLMENT OF MENTALLY RETARDED BY ETHNIC PROJECT COUNTY

Seventeen Counties With Anglo Population Above 91.8%

Counties	Total County Population (1960)	Percent Negro Total County Population (1960)	Percent Spanish Surname Total County Population (1960)	Number of Total County Population Enrolled in State Schools for M.R. 8-31-65	State School Rate per 1,000 Total County Population	State County Public School Enrollment 1963-64	Total County Enrollment in Public School Special Classes for M. R. 1964	Percent of Total School Enrollment in Special Classes for M. R.
Archer	6,110	0.5	0.8	7	1.15	1,460	0	-----
Baylor	5,893	4.0	2.2	4	.68	1,349	0	-----
Clay	8,351	1.0	1.3	11	1.32	1,787	0	-----
Comanche	11,865	0.1	2.0	20	1.69	2,126	16	.75%
Cooke	22,560	3.8	1.9	37	1.64	4,997	22	.44%
Denton	47,432	6.3	1.9	73	1.55	10,920	37	.34%
Eastland	19,526	1.8	4.2	49	2.51	3,622	0	-----
Erath	16,236	0.9	0.9	24	1.58	2,726	28	1.03%
Hood	5,443	1.0	1.8	9	1.65	1,205	11	.91%
Jack	7,418	1.2	0.8	10	1.45	1,522	0	-----
Montague	14,893	.0	0.8	25	1.68	3,160	17	.54%
Palo Pinto	20,516	4.5	4.2	23	1.12	4,715	49	1.14%
Parker	23,808	2.0	2.1	42	1.76	5,177	4	.08%
Stephens	8,885	4.5	2.2	16	1.80	1,588	0	-----
Wise	17,012	0.9	1.4	21	1.23	3,521	29	.82%
Wichita	123,528	8.2	2.8	130	1.05	27,121	111	.41%
Young	17,254	1.6	1.2	22	1.28	3,650	9	.25%
TOTAL	376,730			523		80,646	333	
MEAN		2.49	1.97		1.48			.41%

Mean Anglo Population = 95.54%

TABLE 17

SPECIAL EDUCATION AND STATE SCHOOL ENROLLMENT OF MENTALLY RETARDED BY ETHNIC PROJECT COUNTY

Sixteen Counties With 33% or Above Negro (Non-white)

County	Total Population (1960)	Percent Negro (Non-white)	Number of Total County Population [3]Enrolled in State Schools for M.R. 8-31-65	State School Rate Per 1,000 Population Total County	Total County [1]Public School Enrollment 1963-1964	Total County [2]Enrollment in Public School Special Classes for M.R. 1964	Percent of Total School Enrollment in Special Classes for M.R.
Bastrop	14,842	35%	20	1.35	4,171	0	-----
Burrelson	9,801	35%	16	1.63	2,599	8	.30%
Falls	18,623	37%	31	1.66	4,585	6	.13%
Freestone	12,387	40%	23	1.86	2,848	18	.63%
Grimes	11,805	41%	15	1.27	3,187	19	.60%
Harrison	44,966	44%	42	.93	11,626	93	.80%
Houston	18,982	39%	21	1.12	4,326	0	-----
Marion	7,971	53%	9	1.13	2,082	4	.19%
Morris	21,447	42%	12	.56	3,462	37	1.07%
Newton	10,271	33%	10	.97	2,624	9	.34%
Robertson	14,808	44%	22	1.49	3,824	9	.24%
San Augustine	7,700	39%	9	1.27	2,053	20	.97%
San Jacinto	6,102	53%	15	2.46	1,607	0	-----
Walker	20,850	34%	8	.38	3,612	16	.44%
Waller	11,365	57%	16	1.41	3,019	19	.63%
Washington	15,915	38%	17	1.07	3,935	30	.76%
TOTAL	247,835		286		59,560	288	
MEAN		41.5%		1.29			.48%

Source of data:

[1] Annual Statistical Report 1963-64, Texas Education Agency, April, 1965

[2] Texas Education Agency, September 1, 1964

[3] Data for Planning, Operations Research Division, Texas Department of Mental Health & Mental Retardation March, 1966

TABLE 18

SPECIAL EDUCATION AND STATE SCHOOL ENROLLMENT OF MENTALLY RETARDED BY ETHNIC PROJECT COUNTY

Twelve Counties With 64% or Above Spanish-Surname Population

Counties	Total County Population 1960	Percent Spanish Surname	Number of Total County Population Enrolled in State Schools for M.R. 8-31-65	State School Rate Per 1,000 Total County Population	Total County Enrollment in Public School Special Classes for M.R. 1963-64	Enrollment in Public School Special Classes for M.R. 1963-64	Percent of Total Enrollment in Special Classes for M.R.
Brooks	8,609	68.8	10	1.16	2,313	31	1.34
Cameron	151,098	64.0	122	.81	39,855	635	1.59
Dimmitt	10,095	67.0	6	.59	2,484	0	----
Duval	13,398	73.8	7	.52	3,607	9	.25
Hidalgo	180,904	71.3	139	.77	50,133	20	.04
Jim Hogg	5,022	76.8	2	.40	1,346	0	----
Maverick	14,508	77.5	12	.83	4,612	94	2.04
Starr	17,137	88.6	4	.23	5,079	70	1.38
Webb	64,791	79.9	49	.76	14,973	126	.84
Willacy	20,084	68.3	26	1.39	5,544	50	.90
Zapata	4,393	74.7	0	----	1,108	12	1.18
Zavala	12,696	74.3	6	.47	3,599	15	.42
TOTAL			383		134,635	1,062	
MEAN		73.8%		.76			.79%

Source of data:

[1] Annual Statistical Report 1963-64, Texas Education Agency, April, 1965
[2] Texas Education Agency, September 1, 1964
[3] Data for Planning, Operations Research Division, Texas Department of Mental Health & Mental Retardation

TABLE 19 a, b

INSTITUTIONAL STATUS BY ETHNICITY
ADMISSIONS TO TEXAS STATE SCHOOLS FOR MENTALLY RETARDED
1964 and 1965

TABLE 19a
(MALE)

INSTITUTIONAL STATUS	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
Custodial group	820	56.2	211	62.6	221	62.8
Part-time helper group	275	18.8	59	17.5	63	17.9
Full-time helper group	110	7.5	17	5.0	16	4.5
Potential community returnee	46	3.1	4	1.2	5	1.4

TABLE 19b
(FEMALE)

INSTITUTIONAL STATUS	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
Custodial group	496	51.1	132	62.6	170	69.7
Part-time helper group	219	22.6	27	12.8	34	13.9
Full-time helper group	98	10.1	12	5.7	11	4.5
Potential community returnee	18	1.9	0	0.0	5	2.0

TABLE 20a,b

ADAPTIVE BEHAVIOR BY ETHNICITY AND SEX
ADMISSIONS TO TEXAS STATE SCHOOLS FOR MENTALLY RETARDED
1964 and 1965

TABLE 20a
(MALE)

ADAPTIVE BEHAVIOR LEVEL	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
Level I	377	25.8	94	27.9	121	34.4
Level II	540	37.9	134	39.8	99	28.1
Level III	229	15.7	51	15.1	70	19.9
Level IV	87	6.0	11	3.3	17	4.8
No retardation	5	0.3	1	0.3	0	0.0

TABLE 20b
(FEMALE)

ADAPTIVE BEHAVIOR LEVEL	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
Level I	265	27.3	66	31.3	96	39.3
Level II	348	35.9	69	32.7	81	33.2
Level III	164	16.9	29	13.7	39	15.0
Level IV	48	4.9	6	2.8	4	1.6
No retardation	1	0.0	0	0.0	0	0.0

Education by Ethnic Group

Consistent with information presented in Chapter V, the Latin-American and Negro groups had a higher percent of illiterate parents. The rate of illiteracy for the Latin-American group was almost ten times that of the Anglo and almost five times that of the Negro. The percent of mothers and fathers completing high school showed a reverse pattern. Tables 22 and 23 present data on mothers' and fathers' education by ethnic group.

Religion, Impairment of Special Senses, Parents' Occupation, Convulsive Disorders, Motor Dysfunction by Ethnic Group

The remaining tables 24 to 28 provide data on religion, impairment of special senses, occupation of the principal parent, convulsive disorders, and motor dysfunction by ethnic group for the 1964-1965 admissions. About 88% of the Latin Americans were Catholic; 60% of the Negroes were Baptist; 35% of the Anglos were Baptist, and 11% were Catholic. Well over 60% in each group listed occupation of principal parent in the area of service occupations or did not state degree of skill. About 11% of both the Negroes and Latin Americans indicated no occupation on the form. Approximately 60% of the children in each group had no convulsive disorder present, and the majority in each group had no motor dysfunction.

TABLE 21a, b

SOURCE OF REFERRAL BY ETHNICITY
ADMISSIONS TO TEXAS STATE SCHOOLS FOR MENTALLY RETARDED
1964 and 1965

(MALE)
TABLE 21a

SOURCE OF REFERRAL	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
State board	136	9.3	38	11.3	38	10.8
General hospital, V.A. hospital		0.0	0	0.0	1	0.3
Private specialty institution	9	0.6	1	0.3	2	0.6
State clinic operated by board		0.0				
State operated clinics	5	0.3			1	0.3
Private clinics	3	0.2	1	0.3		
Private physician	12	0.8				
Minister		0.0			1	0.3
Social worker	43	2.9	20	5.9	29	8.2
Health officer	1	0.1	3	0.9	1	0.3
Judge, lawyer, legal referral	47	3.2	36	10.7	22	6.3
Relative	1164	79.7	232	68.8	249	70.7
Friend	35	2.4	5	1.5	8	2.3
Self	1	0.1				

(FEMALE)
TABLE 21b

SOURCE OF REFERRAL	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
State board	156	16.1	19	9.0	33	13.5
General hospital, V.A. hospital						
Private specialty institution	7	0.7			1	0.4
State clinic operated by board						
State operated clinics					1	0.4
Private clinics	1	0.1				
Private physician	9	0.9				
Minister	3	0.3				
Social worker	35	3.6	16	7.6	19	7.8
Health officer	1	0.1	1	0.5		
Judge, lawyer, legal referral	40	4.1	17	8.1	9	3.7
Relative	715	73.7	158	74.9	177	72.5
Friend	3	0.3			4	1.6
Self						

TABLE 22

MOTHER'S EDUCATION BY ETHNICITY
ADMISSIONS TO TEXAS STATE SCHOOLS FOR THE MENTALLY RETARDED
1964 and 1965

MOTHER'S EDUCATION	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
Illiterate	47	1.9	22	4.0	124	20.8
Did not complete grammar school	157	6.5	58	10.6	171	28.7
Completed grammar school only (6th grade)	187	7.7	63	11.5	75	12.6
Completed junior high school (8th grade)	532	21.9	189	34.5	66	11.1
Completed high school	650	26.7	86	15.7	28	4.7
One year college	78	3.2	11	2.0	2	0.3
Two years college	101	4.2	9	1.6	2	0.3
Bachelor degree	97	4.0	7	1.3	4	0.7
Masters degree	9	0.4	0	0.0	0	0.0
Other professional degree	146	6.0	13	2.4	14	2.3
Unknown	424	17.4	90	16.4	110	18.5

TABLE 23

FATHER'S EDUCATION BY ETHNICITY
ADMISSIONS TO TEXAS STATE SCHOOLS FOR THE MENTALLY RETARDED
1964 and 1965

FATHER'S EDUCATION	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
Illiterate	47	1.9	26	4.7	129	20.2
Did not complete grammar school	188	7.7	79	14.4	141	23.8
Completed grammar school only (6th grade)	218	9.0	54	9.9	65	11.0
Completed junior high school (8th grade)	455	18.7	101	18.4	62	10.5
Completed high school	524	21.6	67	12.2	34	5.7
One year college	66	2.7	4	0.7	2	0.3
Two years college	113	4.7	6	1.1	5	0.8
Bachelor degree	145	6.0	3	0.5	4	0.7
Masters degree	39	1.6	3	0.5	0	0.0
Other professional degree	157	6.4	19	3.5	2	0.3
Unknown	475	19.5	187	34.1	149	25.1

TABLE 24

RELIGION BY ETHNICITY
ADMISSIONS TO TEXAS STATE SCHOOLS FOR THE MENTALLY RETARDED
1964 and 1965

RELIGIONS	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
Episcopal	42	1.7		0.0	1	0.2
Methodist	239	9.8	54	9.9	8	1.3
Baptist	858	35.3	328	59.9	19	3.2
Lutheran	68	2.8	2	0.4	0	0.0
Presbyterian	51	2.1		0.0	4	0.7
Pentecostal	46	1.9	2	0.4	7	1.2
Christian	37	1.5	3	0.5	2	0.3
Catholic	273	11.2	19	3.5	520	87.7
Hebrew	15	0.6		0.0	1	0.2
Religion not established	507	20.9	88	16.1	18	3.0
Other (specify)	292	12.0	51	9.3	13	2.2

TABLE 25

IMPAIRMENT OF SPECIAL SENSES BY ETHNICITY
ADMISSIONS TO TEXAS SCHOOLS FOR THE MENTALLY RETARDED
1964 and 1965

IMPAIRMENT OF SPECIAL SENSES	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
With impairment of special senses, but not further specified	96	4.0	12	2.2	14	2.4
No sensory impairment present	1569	60.5	347	63.3	405	68.3
Blind	37	1.5	15	2.7	10	1.7
Deaf	32	1.3	6	1.1	6	1.0
Hearing handicapped	41	1.7	11	2.0	8	1.3
Visually handicapped	173	7.1	36	6.6	48	8.1
Deaf-blind	3	0.1	0	0.0	1	0.2
Blind and hearing handicapped	6	0.2	2	0.4	3	0.5
Deaf and visually handicapped	9	0.4	2	0.4	0	0.0
Hearing and visually handicapped	17	0.7	3	0.5	3	0.5
Other (specify)	62	2.6	15	2.7	19	3.2

TABLE 26

OCCUPATION OF PRINCIPAL PARENT BY ETHNICITY
ADMISSIONS TO TEXAS STATE SCHOOLS FOR THE MENTALLY RETARDED
1964 and 1965

OCCUPATIONS	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
Professional occupations	136	5.6	7	1.3	3	0.5
Semi-professional occupations	45	1.9	2	0.4	3	0.5
Managerial and official occupations	109	4.5		0.0	4	0.7
Clerical and sales	155	6.4	5	0.9	9	1.5
Service occupations	270	11.1	122	22.3	64	10.8
Agricultural, ranching, fishing, forestry, etc.	154	6.3	22	4.0	43	7.3
Degree of skill not stated	866	35.6	204	37.2	262	44.2
Miscellaneous	63	2.6	13	2.4	26	4.4
No occupation	203	8.4	62	11.3	66	11.1
Unknown	402	16.5	105	19.2	112	18.9

TABLE 27

MOTOR DYSFUNCTION BY ETHNICITY
ADMISSIONS TO TEXAS STATE SCHOOLS FOR THE MENTALLY RETARDED
1964 and 1965

MOTOR DYSFUNCTION	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
With motor dysfunction	255	10.5	45	8.2	60	10.1
No motor dysfunction	1357	55.8	289	52.7	319	53.8
Ataxia	40	1.6	9	1.6	8	1.3
Atonia	47	1.9	6	1.1	9	1.5
Athetosis	34	1.4	10	1.8	8	1.3
Chorea	8	0.3	1	0.2	1	0.2
Dystonia	11	0.5	2	0.4	11	1.9
Rigidity	31	1.3	5	0.9	15	2.5
Tremors	13	0.5	1	0.2	1	0.2
Spasticity	221	9.1	76	13.9	18	13.2
Mixed	25	1.0	5	0.9	7	1.2

TABLE 28

CONVULSIVE DISORDERS BY ETHNICITY
ADMISSIONS TO TEXAS STATE SCHOOLS FOR THE MENTALLY RETARDED
1964 and 1965

CONVULSIVE DISORDERS	ANGLO		NEGRO		SPANISH SURNAME	
	Number	Percent	Number	Percent	Number	Percent
With convulsive disorder, but not further specified	237	9.8	61	11.1	64	10.8
No convulsive disorder present	1502	61.8	313	57.1	362	61.0
Akinetic seizures	5	0.2	1	0.2	0	0.0
Autonomic seizures	6	0.2	0	0.0	1	0.2
Focal seizures	9	0.4	3	0.5	0	0.0
Major motor seizures	204	8.4	52	9.5	50	8.4
Mixed or unclassifiable seizures	18	0.7	8	1.5	20	3.4
Myoclonic seizures	18	0.7	5	0.9	4	0.7
Petit mal seizures	28	1.2	3	0.5	9	1.5
Psychomotor seizures	7	0.3	0	0.0	1	0.2
Other (specify)	11	0.5	3	0.5	5	0.8

CHAPTER VIII

MIGRANCY AND MENTAL RETARDATION

In any discussion of ethnic group problems in Texas, special emphasis must be given to the problem of migrant labor. Texas has the largest homebased migrant labor force in the United States. The total number of Texas migrants in interstate as well as intrastate migration, including men, women, and children, was approximately 138,000 in 1964. About 95% of this number are Latin American, making the problems of migrancy and the problems of this minority ethnic group closely interrelated.

Using the three percent prevalence figure suggested by the American Association on Mental Deficiency, The President's Panel on Mental Retardation, and the National Association for Retarded Children, it can be estimated that between 4,000 and 5,000 migrants are mentally retarded. Using the larger figure in Doll's estimate of three to five percent of the population as mentally retarded, the number would be close to 7,000 (Doll, 1962). In some cases, school-age children may remain at home. However, the parents' disinclination to break up the family by leaving the children with relatives and the economic necessity of having the children work in the fields suggests that the retarded child often migrates with his family.

The relationship of poor environment and social disadvantages to mental retardation was discussed in Chapter V. This would tend to support the theory that the incidence of mental retardation among migrant laborers relates directly to their movement from poor environment to poor environment.

What happens to the mentally retarded person who participates in the migration should be subject to a major study. His need for medical care, education, and rehabilitation, if great at home, is no less pressing as he travels. His chances, however, of having these needs met is less as he migrates.

The following information taken from reports of the Texas Council on Migrant Labor, the Texas Education Agency Migrant Project, and the Texas State Department of Health's Migrant Project describes the general characteristics, movement, living conditions, and problems of this large group of people.

General Characteristics of the 1964 Migration

About 93,000 Texas migrants are workers; the rest are family members not working in the fields. Of these workers, the Texas Employment Commission has records on about 65,000 in the interstate migration; it estimated that there were 25,000 intrastate workers, and about 3,000 freewheelers, who traveled entirely on their own without contacting any official agency.

Texas Employment Commission records show that among about 96,000 people in the interstate stream there were 4,264 family groups migrating as family units--that is, not forming part of larger crews under a crew leader or contractor. Using this porportion to determine the number of family groups in the overall stream of 138,000, the number of family units would be about 6,000.

The 4,264 families on record with the Texas Employment Commission include about 24,000 children under 16. Hence the 6,000 families are estimated to contain about 48,900 children under 16.

The average size of family units has in past years been estimated at 6.2 members. It is to be noted that this size refers to families while migrating. Some families leave their school-age children at home; these children are not considered in arriving at the figure of 6.2 members per family.

During recent years, the use of private cars rather than migrating in trucks has increased steadily, indicating a desire on the part of migrant families to travel as units. The proportion of cars to total vehicles has increased from 58% in 1956 to over 71% in 1963.

The new federal Labor Contractor Licensing Law may operate to cause more migrants to travel as small family units in the future, since the licensing law does not apply to such groups.

The average Texas migrant has the equivalent of about four years schooling. Many adults as well as children have never been to school at all. New compulsory school attendance laws and child labor laws will hopefully operate to correct this situation in time.

The majority of migrants speak little English; some do not speak it at all.

Because of the strong influence of parents in the Latin family, it has been frequently observed that juvenile delinquency is low among migrant families when the family travels as a unit.

The principal adverse aspect of children migrating with the family is, of course, that it deprives the children of their education. Already handicapped by the language factor and able to attend school only a few months out of the year, they are unable to keep up with their contemporaries and drop during their third to seventh year.

The economic necessity of having the children work in the fields with their parents and thus contribute to the family's income is the prime reason for taking them along on migration. The parents' disinclination to break up the family by leaving the children with relatives at home is a strong secondary factor.

Among Latin Americans the "family" means, as a rule, the extended family and, even on migration, frequently includes grandparents, uncles or aunts, and brothers or sisters and their spouses. Generally the various members of the extended family live and work in relative harmony.

Problem Areas in Texas Migrant Labor

Texas has by far the largest number of migrant farm workers among the states, and the problems that afflict migrant workers elsewhere in the country are accentuated in Texas. Although Texas migrants have for many decades performed a vital role in the agricultural economy of this and many other states, there remain major problem areas that require remedial action to correct the ills and disadvantages from which this large group of Texas citizens suffers. The problems that traditionally have beset this segment of the Texas population have in recent years been accentuated and intensified by the realities of our present-day technological way of life.

The average yearly income from farm labor of the migrant workers has been reported as less than $1,000 over recent years, and every year it is becoming increasingly difficult for most of them to find steady employment. As a consequence, they must travel farther for fewer days of work. Since these workers are not generally skilled in other work and cannot readily be absorbed in industry or the services, they will become increasingly underemployed. This, in turn, poses a serious problem to the Texas communities where they have their homes, as these communities are entirely unprepared to sustain, by themselves, the large numbers of unemployed with which they will be faced.

The establishment by the governor of an Office of Economic Opportunity to administer the state's anti-poverty program should constitute a long step toward correcting many of the basic handicaps from which the migrants have suffered. The President's Economic Opportunity Act, as well as several other legislative measures enacted or amended in recent years, contain provisions specifically designed to benefit migrant farm workers. At the present time, the Texas Office of Economic Opportunity, under the general guidance of an Inter-Agency Committee for Economic Opportunity, also appointed by the governor, is working out high-priority plans in the area of poverty elimination, with special emphasis on migrant labor. Major specific problem areas are outlined in the following paragraphs.

Education of the Children

The 58th Legislature passed two laws that will do much toward remedying one of the prime problems that existed in the past--the fact that migrant children were denied an adequate education by virtue of their migratory life, their language handicap, and the economic necessity of supplementing the family's income by work in the fields. The new law on child labor (H. B. 165) extends the protection of the Child Labor Law to children hired in agriculture (previously exempted), while the new Compulsory School Attendance Law (H. B. 331) requires all school-age children to attend school for the entire regular school term of the district of their residence. The old law required only 120 days' attendance, and even this minimum was not commonly enforced insofar as migrant children were concerned.

These laws became effective in August 1963, thus having no effect on the 1963 migration. During 1964, however, areas of heavy migrant population received much publicity concerning provisions of the new laws from local school authorities and interested state agencies, church organizations, the League of United Latin American Citizens, the G. I. Forum, and others. As a result, crew leaders and migrant parents have indicated that they are generally aware of the restrictions imposed by the laws. Informal spot checks with school authorities in a few districts indicated that many more migrant children returned to school in September 1964 than in previous years. (Similar checks in April 1965 indicated that a higher number are also staying until schools close.)

Although voluntary compliance has thus far not solved the problem, considerable good has been accomplished, and the trend may grow. Very probably there has also been an increase in the number of children who make an effort to enroll in school in the states to which they travel, in compliance with the Texas law. Certain practical difficulties also affect the extent of voluntary compliance, such as the problem of the care of the children at home while their parents are away, the availability of facilities and teachers in the districts into which migrants travel in large numbers, etc.

A significant trend continues to be observed in the increase in the number of children--school-age as well as younger--who migrate with their families. Among the regular migrants, youths under 16 years of age increased in 1964 to about 46,000, of which about 25,000 were of school age. This trend, which appears to fly in the face of the new child labor and school attendance laws, may actually be due in part, at least, to the increasing number of children born in Latin-American families and to the fact that in ten school districts of heavy migrant population, the special six-months school terms for migrant children allow many of them to accompany their parents on migration; many thousands more work with their families near their homes and are not accounted for in migrant statistics.

The Texas Project for Education of Migrant Children

The State Board of Education, the Commissioner of Education, and other Texas educators have been concerned for a number of years with the problem of educating migrant children. The patterns and practices of mobile families have created school problems for both migrant and nonmigrant students.

In an attempt to find a solution for those problems, the State Board of Education requested a survey in 1962 to determine the number of migratory children and their migration patterns. According to that study there were 48,775 migrant children in Texas in 1961-62. On January 7, 1963, as a result of the survey, the State Board of Education approved the appointment of a commission to consider more effective ways of educating migrant children. The commission, working with the staff of the Texas Education Agency, proposed a six-month school program. Such a program with a longer daily schedule and fewer holidays was designed to provide the same number of instructional hours required in the nine-month program.

The State Board of Education adopted the report of the commission, and in September 1963, the Texas Project for Education of Migrant Children was initiated in five schools, with 3,000 students, located in the Rio Grande Valley. A curriculum guide was developed by a committee composed of public school personnel and members of the Texas Education Agency. Through the Minimum Foundation Program, the Texas Education Agency gave the participating districts financial assistance. The amount of assistance was determined by a formula designed to provide additional classroom teachers in order to retain the desired teacher-pupil ratio during the periods of peak enrollment.

The evaluation at the end of the first year revealed that the students participating in the program had made gains in academic growth and social adjustment comparable to those made by full-time students in the nine-month program. Also it revealed a positive acceptance of the project by teachers, parents, and community leaders.

The instructional program was strengthened by granting special funds to buy instructional materials and equipment and to employ additional teachers and special service personnel.

An additional twenty schools were added to the project in 1965-1966, bringing the total to 40 participating schools with an enrollment of 20,000 students. The greatest concentration of schools is in the Rio Grande Valley, the home base of the largest migrant stream.

Five schools, with an additional 3,000 students, were added to the project at the beginning of the 1965-1965 school year, and during that year plans were made to include an additional ten schools in September 1965.

At the end of the second year it was evident that if the effectiveness of the project were to be truly tested, additional funds were needed. Consequently, the Texas Education Agency through the governor's office made application in 1965 to the United States Office of Economic Opportunity for additional funds to provide medical and welfare services. The Texas Education Agency then allotted the funds to the schools to provide lunches or snacks, clothing, medical examinations, and medical follow-up for those needing these services. (Texas Education Agency 1966 p. 2, 3)

Education of Adults

It has been estimated that the average adult migrant has the equivalent of about a fourth-grade education; many of the migrants have had no formal schooling at all. Texas migrants, for the most part, also have a language handicap and possess little, if any, skills other than in farm labor. Before any considerable number of them can be absorbed in industry or other nonfarm employment, they must be afforded some general education in order that they will be able to absorb vocational training in appropriate skills. Although the problem is complex, and no simple solution is possible, a comprehensive program carried out with funds now becoming available could, in time, reduce substantially the number of illiterates and enable them to absorb the training necessary to become employable in full-time farm work or in nonagricultural vocations.

Texas Employment Commission records indicate that in agriculture alone, there are some thousands of unfilled full-time jobs requiring skills not now possessed by the average migrant. Small-scale programs of training in farm machinery operation that have been conducted in some cities have proved to be very successful, and high rates of employment are reported among those who have taken the courses.

Day-Care Centers

As a rule when parents of migrant children are working in the fields, their small children and infants are either carried into the fields with them or are left in camp under the questionable care of older children. Camp, in many cases, is simply the truck or family car parked at the side of the field. Day-care centers exist at relatively few camps or areas where migrants work; they are usually organized by a few local church women and have little in the way of facilities and less in the way of financial support.

Because of this situation and the general lack of such health factors as sanitation, proper diet, clean water, etc., the infant mortality rate from dysentery and diarrhea is very high among migrants. Nor do the children generally receive the kind of care and training that could prepare them for school later. At all conferences on the problems of migrant labor, the great need for day-care centers is one of the needs most frequently expressed by authorities on the subject.

Housing at Labor Camps

There is no legal authority under which the State Department of Health can require certain standards of health and sanitation at farm labor camps, and the owners of such camps determine what facilities and precautions to maintain on their property. The result is that the adequacy of Texas labor housing varies greatly, ranging from excellent in some instances to deplorable in others. In West Texas many camps are quite adequate, often having cement block houses, screens over doors and windows, approved water supply, metal chemical privies or indoor bathrooms, electricity and cooking heat, etc. But some of the worst housing encountered in various parts of the state does not even have very minimum facilities and sanitation, with the result that the health of the workers and their families, as well as that of the community itself, is endangered.

The migrants consider proper housing one of the most important factors in deciding where to accept employment; they often report that housing in some areas in Texas is the worst they encounter in their migration.

The State Health Department has drawn up a guide for employers of migrants--"Suggested Health Standards for Migratory Labor Camps"--which it makes available to owners of migrant housing during regular visits. But compliance with the suggested standards is voluntary, and the owner may or may not feel like following the suggestions. Since migrants sometimes stay only a few days or weeks in a particular camp, the owner may not feel that any considerable expense in repair his facilities is warranted; but some minimal standards should be required if outbreaks of communicable diseases are to be avoided.

Federal financial assistance for the construction of proper housing has been made available, but has not generally been applied for. Hence this remains an area in which remedial action by the state would have a real and positive effect on the health of the farm labor force.

Rest Camps

Migrants frequently report that while traveling they experience much difficulty in finding rest camps where they can stop, either for a few hours or overnight. Some rest camps are maintained in Texas--the Texas Employment Commission lists 26--but in many large areas there are none. The camps are generally maintained by interested local groups or individuals, so there is considerable variation in the facilities offered. For the most part, however, the better camps consist of a parking area for vehicles, some shower baths, several water hydrants, rest rooms or privies, electric lights, laundry facilities, and cooking facilities--usually masonry barbecue pits. Some of the camps do not have all these facilities.

Migrants are not generally welcome to stop for any length of time at most service stations or roadside travel centers, and along some frequently traveled routes the rest camps are at great distances from each other or are nonexistent. Thus additional rest camps at convenient intervals along usually traveled routes, all equipped with proper minimum facilities, would be of real benefit to the families which follow the crops.

Note: An annotated bibliography on materials relating to Spanish-speaking people of the United States in the migrant labor force may be found in the bibliography section.

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Appendix

PERCENTAGE DISTRIBUTION OF TEXAS POPULATION BY AGE
1960

AGE GROUP	SPANISH WHITE	OTHER WHITE	NEGRO
Under 5	16.7	10.8	14.3
5-9	14.9	10.2	12.5
10-14	12.9	9.1	10.1
15-19	9.2	7.5	7.8
20-24	6.8	6.5	6.4
25-29	6.6	6.5	6.4
30-34	6.6	6.9	6.4
35-39	6.0	7.1	6.1
40-44	4.2	6.4	5.4
45-49	4.0	6.2	5.3
50-54	3.4	5.5	4.7
55-59	2.9	4.7	4.2
60-64	1.9	3.8	3.2
65-69	1.5	3.2	3.0
70-74	1.1	2.4	2.0
75 & over	1.2	3.2	2.3
Median Age	18.0	29.5	24.1

Texas Health Department

MIDWIFE AND HOME DELIVERIES
SPANISH-SURNAME BIRTHS: 1948 - 1965

YEAR	TOTAL BIRTHS	MIDWIFE & OTHER		HOME	
		NUMBER	PERCENT	NUMBER	PERCENT
1948	44,007	14,649	33.3	27,139	61.7
1949	46,725	15,078	32.3	27,269	58.4
1950	49,943	13,520	28.8	25,276	53.8
1951	48,620	12,320	25.3	23,622	48.6
1952	49,944	12,854	25.7	22,265	44.6
1953	51,981	12,722	24.5	21,978	42.3
1954	52,576	11,973	22.8	19,904	37.9
1955*					
1956*					
1957	56,197	9,176	16.3	14,308	25.5
1958	56,438	8,747	15.5	12,736	22.6
1959	58,218	8,665	14.9	11,293	19.4
1960	59,585	8,143	13.7	10,261	17.2
1961	59,236	7,344	12.4	9,619	16.2
1962	60,734	7,019	11.6	8,704	14.3
1963	60,107	6,615	11.0	7,783	12.9
1964	60,471	6,230	10.39	6,756	11.2
1965	55,171	5,533	10.0	6,048	11.0

*Data not available for 1955 and 1956

MIDWIFE DELIVERIES -- PERCENTAGE OF LIVE BIRTHS BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	576	0.4	301	0.2	247	0.2
Mexican American	13,520	28.8	8,043	13.5	5,533	10.0
Negro	6,912	25.2	4,080	11.2	3,103	8.9

HOME DELIVERIES -- PERCENTAGE OF LIVE BIRTHS BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	4,812	3.3	1,110	0.7	432	0.4
Mexican American	25,276	53.8	10,261	17.2	6,048	11.0
Negro	10,523	38.4	4,996	13.7	3,412	9.9

DEATHS FROM GASTROENTERITIS -- RATE PER 100,000 POPULATION
BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	208	3.6	238	3.4	248	3.3
Mexican American	685	66.3	322	22.7	179	11.1
Negro	103	10.5	148	12.3	99	7.6

DEATHS FROM CONGENITAL MALFORMATIONS -- RATE PER 100,000 POPULATION
BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	723	12.7	770	11.1	643	8.5
Mexican American	185	17.9	262	18.5	237	14.7
Negro	85	8.7	149	12.4	150	11.5

DEATHS FROM TUBERCULOSIS -- RATE PER 100,000 POPULATION BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	799	14.0	287	4.1	230	3.0
Mexican American	805	77.9	193	13.6	131	8.1
Negro	328	33.6	94	7.8	73	5.6

DEATHS FROM DYSENTERY -- RATE PER 100,000 POPULATION BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	35	0.6	61	0.9	14	0.2
Mexican American	232	22.4	47	3.3	27	1.7
Negro	23	2.4	18	1.5	18	1.4

DEATHS FROM OTHER DISEASES OF EARLY INFANCY -- RATE PER 1,000 LIVE BIRTHS BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	1,343	10.4	1,133	7.5	871	7.1
Mexican American	708	15.1	554	9.3	389	7.1
Negro	466	17.0	497	13.6	485	14.0

DEATHS DUE TO DIARRHEA OF NEWBORN -- RATE PER 1,000 LIVE BIRTHS BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	13	0.1	9	0.1	7	0.1
Mexican American	43	0.9	32	0.5	21	0.4
Negro	11	0.4	11	0.3	13	0.4

DEATHS FROM BIRTH INJURIES, ATELECTASIS AND POSTNATAL ASPHYXIA
RATE PER 1,000 LIVE BIRTHS
BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	753	5.9	1,028	6.8	656	5.4
Mexican American	253	5.4	383	6.4	310	5.6
Negro	165	6.0	295	8.1	271	7.8

DEATHS FROM INFECTIONS OF NEWBORN -- RATE PER 1,000 LIVE BIRTHS
BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	91	0.7	119	0.8	76	0.6
Mexican American	198	4.2	133	2.2	76	1.4
Negro	45	1.6	94	2.6	73	2.1

INFANT DEATHS -- RATE PER 1,000 LIVE BIRTHS
BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	3,052	23.8	3,111	20.6	2,557	20.8
Mexican American	3,060	65.2	2,496	41.8	1,554	28.2
Negro	1,482	54.1	1,607	44.1	1,438	41.6

MATERNAL DEATHS -- RATE PER 1,000 LIVE BIRTHS
BY ETHNICITY 1950, 1960, 1965

	1950		1960		1965	
	NUMBER	RATE	NUMBER	RATE	NUMBER	RATE
Anglo	81	0.6	29	0.2	23	0.2
Mexican American	70	1.5	42	0.7	37	0.7
Negro	67	2.4	35	1.0	30	0.9

ADMISSIONS TO STATE SCHOOLS FOR MENTALLY RETARDED 1960-1965

Seventeen Counties Above 91.8% Anglo Population

COUNTIES	ANGLO ADMISSIONS	PERCENT	MEXICAN AMERICANS	PERCENT	NEGRO	PERCENT
Archer	4	1.00	0	--	0	--
Baylor	4	1.00	0	--	0	--
Clay	5	1.00	0	--	0	--
Comanche	13	1.00	0	--	0	--
Cooke	21	.95	1	.05	0	--
Denton	56	.98	0	--	1	.02
Eastland	17	.94	1	.06	0	--
Erath	9	1.00	0	--	0	--
Hood	5	1.00	0	--	0	--
Jack	5	1.00	0	--	0	--
Montague	16	1.00	0	--	0	--
Palo Pinto	15	1.00	0	--	0	--
Parker	24	1.00	0	--	0	--
Stephens	9	1.00	0	--	0	--
Wise	15	1.00	0	--	0	--
Wichita	81	.87	5	.05	7	.08
Young	10	1.00	0	--	0	--
TOTALS	309	.95	7	.02	8	.02

Population Mean of Counties 95.54% Anglo

ADMISSIONS TO STATE SCHOOLS FOR MENTALLY RETARDED 1960-1965

Twelve Counties with 64% or Above Spanish-Surname Population

COUNTIES	ANGLO ADMISSIONS	PERCENT	MEXICAN AMERICANS	PERCENT	NEGRO	PERCENT
Brooks	2	.50	2	.50	0	--
Cameron	19	.21	72	.78	1	.01
Dimmit	1	.20	4	.80	0	--
Duval	0	--	3	1.00	0	--
Hidalgo	28	.24	89	.76	0	--
Jim Hogg	0	--	0	--	0	--
Maverick	2	.20	8	.80	0	--
Starr	0	--	1	1.00	0	--
Webb	5	.16	27	.84	0	--
Willacy	6	.29	15	.71	0	--
Zapata	0	--	0	--	0	--
Zavala	6	.47	1	.33	2	.67
TOTALS	39	.15	222	.84	3	.01

Population Mean of Counties = 73.8% Spanish Surname

ADMISSIONS TO STATE SCHOOLS FOR MENTALLY RETARDED 1960-1965

Sixteen Counties with 33% or Above Negro Population

COUNTIES	ANGLO ADMISSIONS	PERCENT	MEXICAN AMERICANS	PERCENT	NEGRO	PERCENT
Bastrop	2	.25	0	--	6	.75
Burrelson	3	.43	0	--	4	.57
Falls	6	.50	0	--	6	.50
Freestone	9	.75	0	--	3	.25
Grimes	4	.33	0	--	8	.67
Harrison	11	.55	0	--	9	.45
Houston	1	.20	0	--	4	.80
Marion	4	.80	0	--	1	.20
Morris	7	.78	0	--	2	.22
Newton	9	1.00	0	--	0	--
Robertson	3	.43	1	.14	3	.43
San Augustine	1	.25	0	--	3	.75
San Jacinto	2	.25	0	--	6	.75
Walker	4	.80	1	.20	0	--
Waller	3	.50	0	--	3	.50
Washington	8	1.00	0	--	0	--
TOTALS	77	.56	2	.01	58	.42

Population Mean of Counties = 41.5% Negro

GUIDE QUESTIONS FOR NEGRO AND LATIN-AMERICAN GROUP MEETINGS

1. Are there subgroups within the major ethnic group with beliefs, understandings (knowledge), or social organization that would affect (a) their perception of mental retardation, (b) their interpretation of mental retardation, (c) their acceptance of the retarded person into the family group, and (d) their seeking of medical treatment or remedial programs?

2. Within the context of the above question, would there be differences in perception, interpretation, acceptance, etc., relative to the degree of mental retardation? For example, would the acceptance of the severely retarded, bedfast child or the child with severe physical defects be different from the more mildly retarded child?

3. Do religious practices or beliefs play an important part in their attitudes, perceptions, acceptance, seeking help, etc., for a mentally retarded child? (Example: seeking medical care or institutionalization)

4. Are there cultural characteristics which influence the seeking and/or utilization of medical care for prevention or treatment of the mentally retarded child? (Example: midwives, curanderos)

5. The proportion of ____________________ enrolled in the State Schools is less than their proportion in the Texas population, whereas the Anglo ethnic group in the state schools for the mentally retarded is larger than their proportion in the population. What are the reasons for this?

6. What are the factors affecting applications to institutions for the mentally retarded? Does this vary with the level of retardation?

7. The proportion of ____________________ enrolled in special education classes for the mentally retarded is generally larger than their proportion in the population. Why is this so, and how is it related to the above questions about institutionalization?

8. Does the family generally make long-range plans regarding the care, treatment, or training of the mentally retarded child?

9. Does the family give serious consideration to what will happen to the mentally retarded child when the parents are no longer able to care for him?

10. In your area of specialization what are the major problems of this group of mentally retarded persons? What are the obstacles to overcoming these problems?

11. What changes may be needed in present services in your area? What new services are needed?

12. What recommendations would you make for the overall improvement of services to mentally retarded persons and their families within this group?

13. Do you feel that the recommendations of the Texas Mental Retardation Planning Study are adequate to improve services for this group?

EXCERPTS FROM TEXAS "STATEWIDE" MIGRANT HEALTH PROJECT
TEXAS STATE DEPARTMENT OF HEALTH, 1965

Project Objectives

The objectives of this project are to assist in providing preventive health measures to the migrant farm laborer. In order to carry out the specific objectives, we found it necessary to work with all local health departments and also to district the state, for specific work, where the migrant laborer is. The plains area of Texas is an out-migrant area; whereas, District II and District III are largely homebase areas. Specifically, the objectives are:

1. To promote and assist those counties without health departments in establishing family service clinics as necessary. These clinics will be organized by local medical people, at the written request of the local medical group, and perform services when the migrant and his family could avail himself to them without too much loss of time from his work.

2. To coordinate activities with other divisions of the State Health Department and other agencies of the State, in the interest of the migrants' health.

3. To coordinate activities with other states where the Texas migrant goes to work.

4. To provide field nursing and sanitarian activities in the form of home and labor camp inspection, with follow-ups and education in basic sanitation, general health, nutrition, and hygiene.

5. To promote education for community leaders and influencial groups on the plight of the migrant.

6. To encourage special health education for the children of migratory farm laborers by supplying the teachers of the ten special migrant schools with enrichment materials and films. This will involve more than 5,000 children in the elementary grades.

Summary of Activities

Due to the shortage of personnel for the period preceding this reporting period, workloads have been heavy. Regardless of this fact, great strides have been made, and credit must be given to those organizations and agencies that have assisted the Texas "Statewide" Migrant Health Project.

Family service clinics have not been established as planned for the Project, due to the fact that a full-time medical director was not available, as explained in the preface. The nursing staff, however, has worked cooperatively with local health departments and local health officers in establishing special immunization clinics, and has made many contacts with persons needing medical assistance and has referred these people to the proper medical authority. In general, the nursing staff has participated in various clinics each week of the reporting period.

The Texas State Department of Health has been very cooperative with this Project, and we have had full and unlimited use of the Division of Health Education. Cooperation has been excellent with other state agencies and other organizations interested in the migrant health problems. The close work with these agencies and organizations has eliminated much duplication and has provided us with additional information that has made our work more effective.

The coordination of activities with other states has been very encouraging. We have a very good referral system now working with the states of Kansas and Ohio, and more effective working relations have been established with other states. The USPHS Personal Health Record is being used and is effective. Standardized referral forms need to be developed for a more effective referral system.

Field nursing and sanitarian services have been provided to the three organized districts in the state by placing one nurse and one sanitarian in each district. Additional personnel is needed, but recruitment has not been possible. District I is an out-migrant situation and Districts II and III are homebase areas. The sanitarians have carried out a very extensive inspection program of both labor camps and homebase housing. Counseling on an individual and group basis has been carried out under both situations, and some improvement has been noted through this type of education. Original inspections are almost completed, and more time will be spent on reevaluation and corrections.

The nursing staff has concentrated on general health, nutrition, and personal hygiene, along with other nursing activities, and by individual and group counseling has made many inroads. Through home visits, at homebase and in the labor camps, many chronic health problems have been detected and properly followed up.

Much emphasis has been placed on community organization by the health educator, as well as the nurses and sanitarians, in order to cause the community to realize the needs of the migrant. This has been accomplished by speaking to civic organizations, church groups, camp owners and managers, and counseling with local officials and leading citizens. The newspaper has been used effectively, and radio and TV have also been used to get the information to the public. District I has been more difficult to influence than have Districts II and III. Also, much time has been given to encouraging local groups to apply for migrant health grants. We have assisted in four grant applications which have been submitted for approval.

We have encouraged the teaching of basic health needs in the ten special schools for children of migratory families by placing into the hands of the teachers more than 100,000 pieces of health literature. This literature covers basic sanitation, dental health, nutrition, and personal hygiene. The teacher teaches a particular subject each week and then sends the material home with the child so he can explain it to his parents. Approximately 6,000 elementary school children will have received this material.